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No. (1)

IN THE

# Supreme Court of the United States

OCTOBER TERM, 1996

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ALLSTATE LIFE INSURANCE COMPANY
*Petitioner,*

v.

MICHAEL HIBMA, *et al.*,
*Respondents.*

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**Petition for a Writ of Certiorari to the Court of Appeals of the State of Arizona**

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## PETITION FOR A WRIT OF CERTIORARI

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## QUESTIONS PRESENTED

The court below held that an employer did not establish an "employee benefit plan" under the Employee Retirement Income Security Act of 1974 ("ERISA") when it arranged for what the court termed "garden variety" group health insurance, enrolled all employees and paid the premiums. In conflict with decisions from numerous Circuits, the court subjected the plan's administration to state law control, thus adding to an increasingly unsettled body of law on what is an ERISA plan. This occurs at a time when Congress is enacting *national* health care reform legislation through ERISA amendments such as the 1996 Health Insurance Portability and Accountability Act. The questions presented are:

1. Whether the employer's selecting and arranging for group health insurance, enrolling all employees, and paying the premiums bring the plan under ERISA.

2. Whether ERISA preempts a participant's state law claims, including a claim for punitive damages, arising from a dispute over plan benefits.

## PARTIES

The petitioner is Allstate Life Insurance Company. The respondents are Prescott Glass Corporation, Michael Hibma, and Robert Hibma and Sharon Hibma, on their own behalf and as guardians of Michelle Hibma, a minor.

Pursuant to Rule 29.6 of the Rules of the Supreme Court, petitioner states that Allstate Insurance Company ("AIC") is the parent of Allstate Life Insurance Company and that they have the following subsidiaries (other than wholly owned subsidiaries): After Six Holding Corporation; After Six Ltd.; Allstate Automobile and Fire Insurance Company, Ltd.; A.S. Licensing; Cardiologic Systems, Inc.; FCOA Acquisition Corp.; Loan Guarantee Investment Corporation; NSI Management, Inc. L.P.S.; Saison Life Insurance Company, Ltd.; Samshim Allstate Life Insurance Company, Ltd; Saugatuck II Cellular Investment Corp.; Science Center Associates; Scripps Center Associates; Tramed; Washington Business Park Associates.*

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* Other significant companies are: Allstate County Mutual Insurance Company (Texas) (a mutual company owned by policy holders; officers and employees of AIC serve as its directors and officers); Allstate Texas Lloyd's (Texas) (an insurance syndicate organized under the laws of Texas); Allstate Texas Lloyd's, Inc. (a direct wholly-owned subsidiary of AIC and the attorney-in-fact for the syndicate).

TABLE OF CONTENTS


| | Page |
|---|---|
| QUESTIONS PRESENTED | i |
| PARTIES | ii |
| TABLE OF AUTHORITIES | iii |
| OPINIONS BELOW | 1 |
| JURISDICTION | 1 |
| STATUTES AND REGULATIONS INVOLVED | 1 |
| STATEMENT OF THE CASE | 2 |
| A. Introduction | 2 |
| B. Factual Background | 3 |
| C. The Trial Court Decision | 4 |
| D. The Court of Appeals Decision | 5 |
| REASONS FOR GRANTING THE WRIT | 6 |
| I. REVIEW OF THE DECISION BELOW IS NECESSARY TO RESTORE CONGRESS' PURPOSE TO PROVIDE EXCLUSIVE, UNIFORM FEDERAL STANDARDS FOR EMPLOYEE BENEFIT PLAN ADMINISTRATION INCLUDING PARTICIPANT PROTECTIONS SUCH AS COBRA AND THE 1996 HEALTH CARE REFORM AMENDMENTS | 9 |
| II. THE DECISION BELOW AND A GROWING NUMBER OF SIMILAR ONES REFUSE TO FOLLOW FEDERAL LAW, THEREBY EXCLUDING VIRTUALLY ALL INSURED HEALTH CARE PLANS FROM ERISA PROTECTIONS | 16 |

TABLE OF CONTENTS—Continued

Page

III. THE DECISION BELOW IS ONE OF A GROWING MINORITY OF STATE AND FEDERAL COURT DECISIONS THAT CONFLICT WITH THE MAJORITY RULE DEVELOPED IN THE FEDERAL CIRCUITS ..... 23

IV. THE QUESTIONS PRESENTED DIRECTLY IMPACT EMPLOYERS NATIONWIDE AND OVER 140 MILLION INDIVIDUALS COVERED BY GROUP HEALTH INSURANCE..... 26

CONCLUSION ..... 29

APPENDIX:

Supplemental Memorandum Decision of the Court of Appeals ..... 1a

Order of the Court of Appeals Dated May 21, 1996 ..... 5a

Memorandum Decision of the Court of Appeals..... 7a

Order of the Court of Appeals Dated March 14, 1996 ..... 14a

Order of the Court of Appeals Denying Petitioner's Motion for Reconsideration of Supplemental Memorandum Decision ..... 16a

Order of the Arizona Supreme Court Denying Review ..... 18a

Order of the Superior Court Denying Petitioner's Motion for Summary Judgment Dated January 14, 1994 ..... 19a

Judgment of the Superior Court ..... 21a

Order of the Superior Court Granting Respondent's Motion for Partial Summary Judgment ..... 23a

TABLE OF CONTENTS—Continued


| | Page |
|---|---|
| Allstate Life's Statement of Facts in Support of Motion for Summary Judgment Dated November 15, 1993 | 26a |
| Allstate Life's Statement of Facts in Support of Motion for Summary Judgment Dated June 15, 1992 | 36a |
| Prescott Glass Group Health Plan | 51a |
| Statement of Facts in Support of Motion for Partial Summary Judgment | 107a |
| ERISA § 3(1), 29 U.S.C. § 1002(1) | 111a |
| ERISA § 3(3), 29 U.S.C. § 1002(3) | 111a |
| ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D) | 111a |
| ERISA § 502(a), 29 U.S.C. § 1132(a) | 112a |
| ERISA § 514(a), 29 U.S.C. § 1144(a) | 113a |
| 29 C.F.R. § 2510.3-1(j) | 114a |

## TABLE OF AUTHORITIES


| *Cases* | Page |
|---|---|
| *Anschultz v. Connecticut Gen. Life Ins. Co.*, 850 F.2d 1467 (11th Cir. 1988) | 11 |
| *Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277 (11th Cir. 1987) | 25 |
| *Berry v. Ciba-Geigy Corp.*, 761 F.2d 1003 (4th Cir. 1985) | 26 |
| *Biggers v. Wittek Indus., Inc.*, 4 F.3d 291 (4th Cir. 1993) | 5, 16 |
| *Bihler v. Eisenberg*, 506 U.S. 818 (1992) | 26 |
| *Blake v. Union-Mutual Stock Life Ins. Co. of Am.*, 906 F.2d 1525 (11th Cir. 1990) | 26 |
| *Blau v. Del Monte Corp.*, 748 F.2d 1348 (9th Cir. 1984), *cert. denied*, 474 U.S. 865 (1985) | 17, 18 |
| *Blue Cross/Blue Shield of Florida, Inc. v. Weiner*, 543 So. 2d 794 (Fla. Ct. App.), *review denied*, 553 So. 2d 1164 (Fla. 1989), *cert. denied*, 494 U.S. 1028 (1990) | 24 |
| *Borst v. Chevron Corp.*, 36 F.3d 1308 (5th Cir. 1994), *cert. denied*, 115 S. Ct. 1699 (1995) | 26 |
| *Brooks v. Burlington Indus., Inc.*, 477 U.S. 901 (1986) | 11 |
| *Brundage-Peterson v. Compcare Health Services Ins. Co.*, 877 F.2d 509 (7th Cir. 1989) | 8, 18, 21, 23, 25 |
| *Cantrell v. Great Republic Life Ins. Co.*, 873 F.2d 1249 (9th Cir. 1989) | 11 |
| *Credit Managers Ass'n v. Kennesaw Life & Acc. Ins. Co.*, 809 F.2d 617 (9th Cir. 1987) | 19 |
| *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. ——, 115 S. Ct. 1223 (1995) | 10 |
| *Daniel v. Eaton Corp.*, 839 F.2d 263 (6th Cir.), *cert. denied*, 488 U.S. 826 (1988) | 26 |
| *Dependahl v. Falstaff Brewing Corp.*, 653 F.2d 1208 (8th Cir.), *cert. denied*, 454 U.S. 968 (1981) | 26 |
| *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982) | 18, 19, 25 |
| *Drinkwater v. Metropolitan Life Ins. Co.*, 846 F.2d 821 (1st Cir.), *cert. denied*, 488 U.S. 909 (1988) | 26 |

TABLE OF AUTHORITIES—Continued

Page

*Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987) ..... 6, 8, 14, 15, 18, 19, 28

*Fugarino v. Hartford Life & Acc. Ins. Co.*, 969 F.2d 178 (6th Cir. 1992), *cert. denied*, 506 U.S. 893 (1993) ..... 25

*Grimo v. Blue Cross/Blue Shield of Vermont*, 34 F.3d 148 (2d Cir. 1994) ..... 25

*Hancock v. Montgomery Ward Long-Term Disability Trust*, 787 F.2d 1302 (9th Cir. 1986) ..... 26

*Harsch v. Eisenberg*, 956 F.2d 651 (7th Cir.), *cert. denied sub nom. Bihler v. Eisenberg*, 506 U.S. 818 (1992) ..... 26

*Haywood v. Russell Corp.*, 584 So. 2d 1291 (Ala. 1991) ..... 26

*Hogan v. Kraft Foods*, 969 F.2d 142 (5th Cir. 1992) ..... 11

*Holland v. Burlington Indus., Inc.*, 772 F.2d 1140 (4th Cir. 1985) ..... 11

*International Resources, Inc. v. New York Life Ins. Co.*, 950 F.2d 294 (6th Cir. 1991 ..... 8, 11, 19, 21

*James v. National Business Sys., Inc.*, 924 F.2d 718 (7th Cir. 1991) ..... 18

*Jeanette M. v. Blue Cross/Blue Shield of Louisiana*, 662 So. 2d 498 (La. App. 1995), *cert. denied*, 667 So. 2d 1054 (La. 1996) ..... 24

*Johnson v. District 2 Marine Eng'g Beneficial Ass'n*, 857 F.2d 514 (9th Cir. 1988) ..... 26

*Johnson v. Watts Regulator Co.*, 63 F.3d 1129 (1st Cir. 1995) ..... 25

*Jordan v. Reliable Life Ins. Co.*, 694 F. Supp. 822 (N.D. Ala. 1988) ..... 25

*Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988), *cert. denied*, 492 U.S. 906 (1989) ..... 8, 11, 19, 20, 25

*Kidder v. H&B Marine, Inc.*, 932 F.2d 347 (5th Cir. 1991) ..... 20

*Kirk v. Provident Life & Acc. Ins. Co.*, 942 F.2d 504 (8th Cir. 1991) ..... 26

*Kleinhans v. Lisle Savings Profit Sharing Trust*, 810 F.2d 618 (7th Cir. 1987) ..... 26

TABLE OF AUTHORITIES—Continued

Page

*Lafoy v. HMO Colorado*, 988 F.2d 97 (10th Cir. 1993) ..... 26

*Madonia v. Blue Cross & Blue Shield of Virginia*, 11 F.3d 444 (4th Cir. 1993), *cert. denied*, 114 S. Ct. 1401 (1994) ..... 25

*Marshall v. Bankers Life & Casualty Ins. Co.*, 2 Cal. 4th 1045, 10 Cal. Rptr. 2d 72, *cert. denied*, 506 U.S. 1000 (1992) ..... 6, 18, 20, 24

*Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985) ..... 25

*Massachusetts v. Morash*, 490 U.S. 107 (1989) ..... 15

*McRae v. Seafarers Welfare Plan*, 920 F.2d 819 (11th Cir. 1991) ..... 26

*Medina v. Anthem Life Ins. Co.*, 983 F.2d 29 (5th Cir.), *cert. denied*, 510 U.S. 816 (1993) ..... 26

*Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990) ..... 20, 25

*Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993) ..... 24, 25

*In re Metropolitan Life Ins. Co.*, 679 So. 2d 686 (Ala. 1996) ..... 25

*Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359 (1980) ..... 9

*Nationwide Mut. Life Ins. Co. v. Darden*, 503 U.S. 318 (1992) ..... 5

*Nevill v. Shell Oil Co.*, 835 F.2d 209 (9th Cir. 1987) ..... 26

*New York State Conference of Blue Shield & Blue Cross Plans v. Travelers Ins. Co.*, 514 U.S. ——, 115 S. Ct. 1671 (1995) ..... 7, 11, 12, 13, 22, 23, 27

*Pane v. RCA Corp.*, 868 F.2d 631 (3d Cir. 1989) ..... 26

*Peters v. Boulder Ins. Agency, Inc.*, 829 P.2d 429 (Colo. Ct. App. 1991), *cert. denied*, 1992 Colo. LEXIS 332 ..... 24

*Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) ..... 7, 8, 9, 11, 15, 23, 25, 28

*Powell v. Chesapeake & Potomac Telegraph Co. of Virginia*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986) ..... 26

*Qualls v. Blue Cross of California, Inc.*, 22 F.3d 839 (9th Cir. 1994) ..... 8, 19, 20, 21, 23, 25

TABLE OF AUTHORITIES—Continued

Page

*Randol v. Mid-West Nat'l Life Ins. Co. of Tennessee*, 987 F.2d 1547 (11th Cir.), *cert. denied*, 510 U.S. 863 (1993) ..... 21
*Robertson v. Gem Ins. Co.*, 828 P.2d 496 (Utah App. 1992) ..... 6, 24
*Roe v. General Am. Life Ins. Co.*, 712 F.2d 450 (10th Cir. 1983) ..... 25
*Sarraf v. Standard Ins. Co.*, 102 F.3d 991 (9th Cir. 1996) ..... 20
*Sayble v. Blue Cross of Southern California*, 256 Cal. Rtpr. 820 (1989) ..... 6, 24
*Scott v. Gulf Oil Corp.*, 754 F.2d 1499 (9th Cir. 1985) ..... 18
*Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983) .. 10, 18
*Sofo v. Pan-American Life Ins. Co.*, 13 F.3d 239 (7th Cir. 1994) ..... 11, 25, 26
*Sokol v. Bernstein*, 803 F.2d 532 (9th Cir. 1986) .... 26
*Spinelli v. Gaughan*, 12 F.3d 853 (9th Cir. 1993). 26
*Sullivan v. LTV Aerospace & Defense Co.*, 82 F.3d 1251 (2d Cir. 1996) ..... 26
*Taggart Corp. v. Life & Health Benefits Admin., Inc.*, 617 F.2d 1208 (5th Cir. 1980), *cert. denied*, 450 U.S. 1030 (1981) ..... 25
*Texas Carbonate v. Phinney*, 307 F.2d 289 (5th Cir.), *cert. denied*, 371 U.S. 940 (1962) ..... 5
*Turnbow v. Pacific Mut. Life Ins. Co.*, 765 P.2d 1160 (Nev. 1988), *cert. denied*, 490 U.S. 1102 (1989) ..... 24
*Varhola v. Doe*, 820 F.2d 809 (6th Cir. 1987) ..... 26
*Villescas v. CNA Ins. Cos.*, 864 P.2d 288 (Nev. 1993) ..... 24
*Wadsworth v. Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978) ..... 9
*Wayne Chemical, Inc. v. Columbus Agency Service Corp.*, 567 F.2d 692 (7th Cir. 1977) ..... 25
*Weems v. Jefferson-Pilot Life Ins. Co.*, 663 So. 2d 905 (Ala.), *cert. denied*, 116 S. Ct. 434 (1995) .. 25, 26
*Williams v. Wright*, 927 F.2d 1540 (11th Cir. 1991) ..... 5, 16

TABLE OF AUTHORITIES—Continued


*Statutes and Regulations* Page

28 U.S.C. § 1257 ..... 1
29 U.S.C. § 630 ..... 17
29 U.S.C. § 1001(a) ..... 7, 9
29 U.S.C. § 1002(1) ..... 5, 7, 16, 17, 19, 22
29 U.S.C. § 1002(3) ..... 1
29 U.S.C. § 1003 ..... 16, 22
29 U.S.C. § 1022(b) ..... 17
29 U.S.C. § 1023(a)(2) ..... 17
29 U.S.C. § 1101(b)(2) ..... 17
29 U.S.C. § 1102(a)(1) ..... 10
29 U.S.C. § 1104(a) ..... 10
29 U.S.C. § 1104(a)(1)(D) ..... 10
29 U.S.C. § 1105(c) ..... 13
29 U.S.C. § 1132(a) ..... 1, 11
29 U.S.C. § 1132(e)(1) ..... 10
29 U.S.C. § 1135 ..... 25
29 U.S.C. § 1140 ..... 10
29 U.S.C. § 1144(a) ..... 1, 11
29 U.S.C. § 1161 ..... 9, 12
29 U.S.C. §§ 1181-83 ..... 9
29 U.S.C. § 1185 ..... 9
29 U.S.C. § 1185a ..... 9, 12
29 U.S.C. § 1191a(a) ..... 12
29 U.S.C. § 1191b(a)(1) ..... 12
42 U.S.C. § 2000e(b) ..... 17
42 U.S.C. § 12111(5)(A) ..... 17
29 C.F.R. § 2510.3-1 ..... 1, 21, 22, 25
29 C.F.R. § 2560.503-1 ..... 13, 17

*Legislative History*

120 CONG. REC. 29192, 29197 (1974) (remarks of Rep. Dent) ..... 10
120 CONG. REC. 29928, 29933 (1974) (remarks of Sen. Williams) ..... 10
H.R. REP. No. 496, 104th Cong. 2d Sess. 1871 (1996) ..... 12
Department of Labor's Explanatory Statement, 40 FED. REG. 34526, 34527 (Aug. 15, 1975) ..... 20

TABLE OF AUTHORITIES—Continued

Page

EMPLOYEE BENEFIT SECURITY ACT OF 1973, H.R. REP. No. 533, 93d Cong., 1st Sess. 12 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4656 ..... 17

*Employee Retirement Income Security Act of 1974; Material Explaining H.R. 12906*, 120 CONG. REC. 3977, 3981-82 (1974) ..... 9

RETIREMENT INCOME SECURITY FOR EMPLOYEES ACT OF 1973, S. REP. No. 127, 93d Cong., 1st Sess. 6 (1978), *reprinted in* 1974 U.S.C.C.A.N. 4838, 4842-43 ..... 16, 17

Welfare and Pension Plans Disclosure Act, Pub. L. No. 85-836, 72 Stat. 997 ..... 16

*Miscellaneous*

1996 FOSTER HIGGINS NATIONAL SURVEY OF EMPLOYER SPONSORED HEALTH PLANS 18-19 ..... 2, 8, 10, 14, 27

BATELLE HUMAN AFFAIRS RESEARCH CENTERS, 4 EMPLOYEE WELFARE BENEFIT PLANS AND PLAN SPONSORS IN THE PRIVATE NONFARM SECTOR IN THE UNITED STATES ..... 10, 14, 27

R. J. COOKE, ERISA PRACTICE & PROCEDURE § 2.05 (Shepards/McGraw Hill 1994) ..... 8

D. L. Bacon, *An ERISA Plan: What Is It?* in AMERICAN BAR ASS'N CENTER FOR CONTINUING LEGAL EDUCATION, ERISA BASICS: A PRIMER ON ERISA ISSUES § 3 (1996) ..... 8

D. BACON, S. PRATER, D. TUCKER, EMPLOYEE BENEFITS GUIDE § 202[3] (Matthew Bander & Co. 1996) ..... 5, 23

O. Mitchell & E. Andrews, *Scale Economics in Private Multi-Employer Pension Systems*, 34 INDUS. & LABOR RELATIONS L. REV. 522, 527 (1981) ..... 14

Scallet, *The Regulation of Multiple Employer Trusts: Past, Present & Future*, 61 WASH. U. L.Q. 359, 381 (1983) ..... 13, 14

## PETITION FOR A WRIT OF CERTIORARI

Petitioner, Allstate Life Insurance Company, respectfully prays that a writ of certiorari issue to review the order of the Court of Appeals of the State of Arizona entered in this proceeding on March 14, 1996, and supplemented on May 21, 1996. The Arizona Supreme Court denied a petition for review on December 17, 1996.

### OPINIONS BELOW

The supplemental opinion and opinion of the Arizona Court of Appeals are unreported and appear in the Appendix at 1a to 4a and 7a to 13a, respectively. The judgment of the Maricopa County Superior Court against petitioner (21a to 22a) is unreported, and that court's order denying petitioner's motion for summary judgment (19a to 20a) was entered without opinion and is unreported.

### JURISDICTION

The supplemental opinion and opinion of the Arizona Court of Appeals of which petitioner seeks review were filed on May 21, 1996, and March 14, 1996, respectively. The Court of Appeals denied a timely motion for reconsideration of the supplemental opinion (16a to 17a) on June 13, 1996. The Arizona State Supreme Court denied a timely petition for review (18a) on December 17, 1996. This petition is timely filed within 90 days of that denial. The jurisdiction of this Court is invoked under 28 U.S.C. § 1257.

### STATUTES AND REGULATIONS INVOLVED

This case involves sections 3(1), (3), 404(a)(1)(D), 502(a) and 514(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. §§ 1002(1), (3), 1104(a)(1)(D), 1132(a), 1144(a), and 29 C.F.R. § 2510.3-(j). The pertinent text of these statutes and regulations is set forth in the Appendix at 111a to 114a.

## STATEMENT OF THE CASE

### A. Introduction

The Arizona Court of Appeals, with review denied by the Arizona Supreme Court, held that an employer does not create an ERISA plan where it selects and arranges group health insurance coverage as a benefit for its employees, giving the employees no choice in the type of insurance offered, enrolls all of the employees, pays the premiums, and retains the right to terminate the policy—unless the *employer itself* (as distinguished from the insurance company)—is engaged in "administrative activity potentially subject to . . . abuse" that ERISA was designed to cover. The court then allowed the participants to use state law to overturn the plan's written "Medical Benefit" and termination provisions, and to proceed with state law extracontractual claims, including punitive damages. The ruling, moreover, was not confined to small or medium-sized employers; it applies across the board to all employers.

The *facts* in this case thus involve common, everyday business transactions, what the Arizona court accurately termed *"garden variety"* group health insurance. The plan was "garden variety" indeed—over 148 million individuals in the United States are covered by private sector employer-sponsored group health insurance [1] that is virtually identical to the coverage in this case, and, for 91% of these plans, the employers do *not* handle plan administration. Rather, it is performed by commercial insurers, Blue Cross/Blue Shield plans or third-party administrators.[2]

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[1] STATISTICAL ABSTRACT OF THE UNITED STATES 118 (115th ed. 1995).

[2] 1996 FOSTER HIGGINS NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS 18-19 [*hereinafter* 1996 FOSTER HIGGINS SURVEY].

**B. Factual Background**

In 1987, respondent Prescott Glass Corporation ("Prescott Glass"), an Arizona employer, arranged for the purchase of a group health, life and accidental death and dismemberment insurance plan (the "Plan") covering its employees. The insurer was Allstate Life Insurance Company ("Allstate Life"), a subsidiary of Allstate Insurance Company.[3] Respondent Robert Hibma, the sole shareholder and president of Prescott Glass, solely selected and negotiated the purchase of the Plan through an Allstate Insurance Company insurance agent with whom Prescott Glass regularly dealt. Mr. Hibma "wanted to make sure [he] had a good major medical insurance plan for [himself] and [his] employees." Prescott Glass became a participating employer under a group insurance policy issued by Allstate Life to the Trustee of the First Insurance Trust (the "Group Policy"). The Plan covered Robert Hibma and Richard Hull, as Prescott Glass employees, as well as Sharon Hibma (Robert's wife and a Prescott Glass employee) and respondent Michael Hibma (Robert and Sharon's son), as Robert Hibma's eligible dependents. Because Prescott Glass would be paying the premiums, Robert Hibma did not even ask Mr. Hull for input in what insurance coverage to pursue. Prescott Glass enrolled all of its employees, was billed for and paid the insurance premiums (remitting them to Allstate Life), and reserved the right to terminate the policy. The Plan's group insurance certificate specified under "Medical Benefit" that the "Medical Benefit is paid for Eligible Expense[s] incurred for an Injury or Sickness while insured," and the certificate stated that Allstate Life had the right to terminate the Group Policy on any premium due date upon 60 days' written notice.

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[3] The pleadings below at times alternately describe Allstate Life as "Allstate Life Insurance Company" or "Allstate Insurance Company."

On February 15, 1988, Michael Hibma was seriously injured while driving an all-terrain vehicle. On February 17, 1989, Allstate Life notified Prescott Glass and other employers that it was withdrawing from the group health insurance market and that, effective May 1, 1989, it would terminate the Group Policy and all employer plans issued thereunder, including the Prescott Glass Plan. Michael Hibma qualified for a 12-month extension of benefits under the Plan. The Hibmas did not exercise their right to buy a conversion health insurance policy under the Plan.

**C. The Trial Court Decision**

Prescott Glass and the Hibmas sued Allstate Life in April of 1990 under state law in Arizona Superior Court seeking, among other things, health insurance benefits and punitive and other extracontractual damages for its termination of group insurance coverage.[4] In its answer, Allstate Life asserted that the termination of insurance was proper under the Plan's express written provisions, and that ERISA preempts the Hibmas' state law causes of action. On cross motions for partial summary judgment filed in June of 1992, the trial court (23a to 25a) applied state law and held that Allstate Life's termination of Michael Hibma's insurance coverage was contrary to the Hibmas' reasonable expectations and, therefore, a breach of its obligations under the Plan.

Following the close of discovery, Allstate Life filed a motion for partial summary judgment on the question of whether ERISA governs the Plan's terms and preempts the Hibmas' state law claims for punitive and other extracontractual damages. The trial court (19a to 20a) denied the motion without comment. The Hibmas and Allstate Life subsequently entered into a "high-low" settlement agreement (the "Settlement Agreement"), pursuant to which the amount of the Hibmas' recovery will depend on how the ERISA preemption question is de-

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[4] Other defendants in the suit have been dismissed.

cided on appeal.[5] The parties further agreed to the entry of judgment against Allstate Life in the amount of $1 to facilitate an appeal.

**D. The Court of Appeals Decision**

The Arizona Court of Appeals affirmed the denial of summary judgment.[6] It held that the employer, Prescott Glass, did *not* establish an ERISA-covered health care plan when, as a benefit to its employees, it selected and arranged for the purchase of group health care insurance, giving the employees no choice in the type of insurance offered, enrolled all of them and retained the right to

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[5] The Settlement Agreement attached by the Hibmas to their motion for reconsideration in the Court of Appeals reflects that the "low" amount is $225,000, and that the "high" amount (an additional $775,000) becomes payable only if an appellate court of last resort determines that ERISA does not apply to the Plan or that it does not preempt the Hibmas' claims for punitive and other extracontractual damages.

[6] The Court of Appeals *initially* held that conflicting testimony in the record whether Mr. Hull ever reimbursed Prescott Glass for any of his premiums was an unresolved issue of material fact. The court ignored the undisputed facts that Prescott Glass had paid for *Robert Hibma's* premiums and that he was its employee. *See, Texas Carbonate v. Phinney*, 307 F.2d 289 (5th Cir.) (shareholder officer is employee), *cert. denied*, 371 U.S. 940 (1962). It also ignored the undisputed fact that Prescott Glass paid the first month's premiums for *all* employees including Mr. Hull. An ERISA plan only requires that *one* common law employee be covered. ERISA § 3(1), 29 U.S.C. § 1002(1), *Williams v. Wright*, 927 F.2d 1540 (11th Cir. 1991); *Biggers v. Wittek Indus., Inc.*, 4 F.3d 291, 297 (4th Cir. 1993). Because Mr. Hibma satisfied ERISA's definition of an "employee," § 3(6), 29 U.S.C. § 1002(6), *see Nationwide Mut. Life Ins. Co. v. Darden*, 503 U.S. 318 (1992), an ERISA plan was established *without regard* to whether Mr. Hull reimbursed Prescott Glass for insurance premiums. ERISA § 3(1), 29 U.S.C. § 1002(1); D. BACON, S. PRATER, D. TUCKER, EMPLOYEE BENEFITS GUIDE § 2.02[4] (Matthew Bender & Co. 1996); R. ECCLES & D. GORDON, *"Supreme Court Adopts Common-Law Test For Determining Who Is An Employee Under ERISA,"* ERISA LITIGATION REPORTER 3-6 (April 1992). After the parties filed motions for reconsideration, the Court of Appeals *reversed* itself in a supplemental opinion that noted the prior decision had failed to trigger the high-figure provisions of the Settlement Agreement.

terminate the policy. The appeals court assumed for purposes of the motion that Prescott Glass paid all of the insurance premiums. The court concluded that " 'garden variety employee health insurance benefits' " are not subject to ERISA unless the *employer*—as distinguished from the insurance company—engages in "administrative activity potentially subject to employer abuse." (3a to 4a.) Accordingly, it held that the Plan was not ERISA-covered and that the suit against Allstate Life was not subject to ERISA's preemption clause or its enforcement provisions.

In so doing, the Arizona Court of Appeals expressly relied on a growing series of state and federal court decisions, including a questionable Utah Court of Appeals decision, *Robertson v. Gem Ins. Co.*, 828 P.2d 496 (Utah App. 1992). *Robertson* adopted a highly restrictive definition of "employee benefit plan" by holding that unless the *employer* plays an active role in administering a group insurance plan, ERISA coverage does not exist. This Court, in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 12 (1987), has held that ERISA only requires an "ongoing administrative program for processing claims and paying benefits" in order for a "plan" to exist. *Robertson* relied on a California Court of Appeals decision, *Sayble v. Blue Cross of Southern California*, 256 Cal.Rptr. 820 (1989), which gave a simple blueprint for employers to "opt out" of ERISA regulation: merely buy an "off the shelf" package of group health care benefits funded and administered by an insurance company. The California Supreme Court ordered *Sayble de-published* on June 8, 1989, *id.*, and effectively overruled it in *Marshall v. Bankers Life & Cas. Ins. Co.*, 2 Cal.4th 1045, 10 Cal.Rptr. 2d 72, *cert. denied*, 506 U.S. 1000 (1992).

## REASONS FOR GRANTING THE WRIT

Over the last 10 years, a growing number of state courts, with some federal courts following the lead, have refused to acknowledge that insured employee welfare benefit plans and, in particular, health care plans are

*not* subject to state law control over their administration and therefore are *not* subject to state law extracontractual damages awards. Most often, this resistance has taken the form of decisions, such as the present one, simply declaring that such plans are "non-ERISA" because plan administration is not handled by the employer but rather by an insurance company, a Blue Cross/Blue Shield plan or a third-party administrator. These decisions have overturned Congress' goal of uniform federal protection and regulation of the administration of *all* employee welfare benefit plans, self-funded and insured alike. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45-46 (1987). At the same time, they have created an increasingly unsettled and conflicting body of law in the lower courts as to what constitutes an ERISA plan. The respective rights and obligations of employers, insurance companies, the Blue Cross/Blue Shield plans and participants and beneficiaries have been thrown into confusion, the exact opposite of what Congress intended. It is essential for this Court to intervene in this area of significant public concern affecting literally *millions* of welfare plans and to preserve the federal statutory scheme and comprehensive civil enforcement remedies so carefully crafted by Congress. The Arizona Court of Appeals' decision deliberately upsets ERISA's intricate framework in many significant respects, all of which warrant review by this Court:

(1) In departing from the plain meaning of ERISA's definition of "employee welfare benefit plan," ERISA § 3(1), 29 U.S.C. § 1002(1), the Arizona court and others like it, in essence, would subject the administration of ERISA plans, which are "affected with a national public interest," § 2(a), 29 U.S.C. § 1001(a), and whose regulation is " 'exclusively a federal concern,' " *Pilot Life*, 481 U.S. at 45-46 (citation omitted), to complete state law control, including interference with substantive plan provisions and the imposition of punitive damage awards.

(2) Congress intended ERISA to provide for "nationally uniform administration" of *all* employee benefit plans. *New York State Conference of Blue Shield &*

*Blue Cross Plans v. Travelers Ins. Co.*, 514 U.S. ——, ——, 115 S.Ct. 1671, 1677-78 (1995). Over 148 million individuals are covered by private sector employer-sponsored group health insurance,[7] with 91% of these plans being administered by parties *other* than the employers—such as commercial insurers, Blue Cross/Blue Shield plans and third-party administrators.[8] The consensus among employers and administrators is that *all* of these plans are covered by ERISA.[9] The Arizona decision, and similar ones, would overturn ERISA's statutory scheme of "nationally uniform administration" by jettisoning virtually *all* employer-sponsored group health insurance from its comprehensive regulation and protections.

(3) The practical effects of the Arizona decision and similar ones will be to resurrect state law as the principal mechanism for regulating insured employee benefit plans, many of which are multi-state in operation; to reopen a door to punitive damages closed by *Pilot Life*, thus raising substantial economic disincentives to insured plans despite a "strong public interest in encouraging the formation . . . of [ERISA] plans," *id.* at 54; and to increase transaction costs which will ultimately require employers to reduce group insurance benefits or eliminate them altogether, *see Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 13 (1987).

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[7] STATISTICAL ABSTRACT OF THE UNITED STATES 118 (115th ed. 1995).

[8] 1996 FOSTER HIGGINS SURVEY, *supra* note 2, at 18-19.

[9] *See e.g.*, R.J. COOKE, ERISA PRACTICE & PROCEDURE § 2.05 (Shepard's/McGraw Hill 1994); EMPLOYMENT COORDINATOR ¶ B-10,613 (Clark Boardman Callaghan 1997); D.L. Bacon, *An ERISA Plan: What Is It?* in AMERICAN BAR ASSOCIATION CENTER FOR CONTINUING LEGAL EDUCATION, ERISA BASICS: A PRIMER ON ERISA ISSUES § 3 (1996); *see also Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489, 492 (9th Cir. 1988) (as amended, 1989), *cert. denied*, 492 U.S. 906 (1989); *Qualls v. Blue Cross of California, Inc.*, 22 F.3d 839, 843 (9th Cir. 1994); *Brundage-Peterson v. Compcare Health Services Ins. Co.*, 877 F.2d 509, 511 (7th Cir. 1989); *International Resources, Inc. v. New York Life Ins. Co.*, 950 F.2d 294, 297-98 (6th Cir. 1991), *cert. denied*, 112 S.Ct. 2491 (1992).

(4) The Arizona decision's "*ripple*" effects will be to deny participants and beneficiaries in "garden variety" health care plans *all* of ERISA's substantive and procedural protections, including COBRA health care continuation rights [10] and the rights added by the recent national health care reform amendments to ERISA—the Health Insurance Portability and Accountability Act of 1996,[11] the Mental Health Parity Act of 1996,[12] and the Newborns' and Mothers' Health Protection Act of 1996.[13]

## I. REVIEW OF THE DECISION BELOW IS NECESSARY TO RESTORE CONGRESS' PURPOSE TO PROVIDE EXCLUSIVE, UNIFORM FEDERAL STANDARDS FOR EMPLOYEE BENEFIT PLAN ADMINISTRATION INCLUDING PARTICIPANT PROTECTIONS SUCH AS COBRA AND THE 1996 HEALTH CARE REFORM AMENDMENTS.

ERISA is a "comprehensive and reticulated statute," *Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359, 361-62 (1980), designed to make the *regulation* of employee benefit plans "'exclusively a federal concern.'" *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45-46 (1987) (citation omitted). ERISA is built on the premise that employers should be *encouraged* to provide employee benefit plans, *see* ERISA § 2(a), 29 U.S.C. § 1001(a), and Congress recognized that cost-effective group insurance was essential to this goal. *Employee Retirement Income Security Act of 1974: Material Explaining H.R. 12906*, 120 CONG. REC. 3977, 3981-82 (1974); *Wadsworth v. Whaland*, 562 F.2d 70, 78 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978) (Congress was aware that insurance was the most common source of plan funding). Indeed, insured health care plans, health maintenance organization ("HMO") plans, and Blue Cross/

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[10] ERISA § 601, 29 U.S.C. § 1161.

[11] ERISA §§ 701-703, 29 U.S.C. §§ 1181-83.

[12] ERISA § 712, 29 U.S.C. § 1185a.

[13] ERISA § 711, 29 U.S.C. § 1185.

Blue Shield plans are the *only* realistic choices available to small and medium sized employers.[14]

In enacting ERISA, Congress also sought to replace the conflicting system of state and local regulation with "a *uniform* source of law for evaluating . . . fiduciary conduct" thereby ensuring "*national uniformity*" in employee benefit plan administration. *See Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99 n. 20 (1983) (emphasis added); Introductory statement of Senator Javits on S. 1557, *reprinted in* 1 LEGISLATIVE HISTORY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 at 273, 279 (1976); *see also* 120 CONG. REC. 29928, 29933 (1974) (remarks of Sen. Williams); *id.* 29192, 29197 (remarks of Rep. Dent). To establish federal preeminence, Congress enacted a detailed set of standards and duties to guide fiduciaries in the field of plan administration for both insured and self-funded plans. ERISA §§ 404(a)-412, 29 U.S.C. §§ 1104(a)-1112. These fiduciary standards include a requirement that *all* plans be in writing and administered in accordance with their written terms, ERISA §§ 402(a)(1), 404(a)(1)(D), 29 U.S.C. §§ 1102(a)(1), 1104(a)(1)(D), a "written plan instrument" rule which is "one of ERISA's core functional requirements." *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. ——, ——, 115 S.Ct. 1223, 1230 (1995). Additionally, Congress passed civil and criminal safeguards to protect against *interference* with ERISA rights. ERISA §§ 510-11, 29 U.S.C. §§ 1140-41. To underscore the importance of federal control in this area, Congress vested the federal courts with *exclusive* jurisdiction over suits alleging a breach of fiduciary responsibility or interference with protected rights. ERISA § 502(e)(1), 29 U.S.C. § 1132(c)(1).

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[14] 1996 FOSTER HIGGINS SURVEY, *supra* note 2, at Table 9.1; BATELLE HUMAN AFFAIRS RESEARCH CENTERS, 4 EMPLOYEE WELFARE BENEFIT PLANS AND PLAN SPONSORS IN THE PRIVATE NONFARM SECTOR IN THE UNITED STATES: 1978-79 at 25, 28, 37-38 [*hereinafter* BATELLE STUDY].

To ensure that state law would not intrude in the regulation of ERISA-covered plans, Congress armed the statute with a preemption clause of "unparalleled breadth." *Holland v. Burlington Indus., Inc.*, 772 F.2d 1140, 1147 (4th Cir. 1985), *summarily aff'd sub nom. Brooks v. Burlington Indus., Inc.*, 477 U.S. 901 (1986); *see* ERISA § 514(a), 29 U.S.C. § 1144(a). Congress added a "comprehensive civil enforcement scheme," *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. ——, ——, 115 S.Ct. 1671, 1674 (1995), which has its own "pre-emptive" force and provides an "exclusive" federal remedy in suits alleging wrongful cancellation of insurance or claims disputes under either self-funded or insured plans. *Pilot Life*, 481 U.S. at 54-56; *see* ERISA § 502(a), 29 U.S.C. § 1132(a); *Cantrell v. Great Republic Life Ins. Co.*, 873 F.2d 1249, 1253 (9th Cir. 1989); *Sofo v. Pan-American Life Ins. Co.*, 13 F.3d 239, 241 (7th Cir. 1994); *International Resources, Inc. v. New York Life Ins. Co.*, 950 F.2d 294, 299 (6th Cir. 1991).[15] This Court recently reaffirmed that ERISA preempts state laws that "mandate[] employee benefit structures or their administration" or that provide "alternate enforcement mechanisms." *Travelers*, 115 S.Ct. at 1678.

In late 1996, Congress enacted major health care reform legislation (through the device of ERISA amendments) which grants employee protections and requires both insured and self-funded "group health plans" to provide specified medical benefits. *See* Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Mental Health Parity Act of 1996 ("MHPA"), and Newborns' and Mothers' Health Protection Act of 1996

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[15] In the area of claims processing, ERISA preemption includes both state common law claims, *Pilot Life*, 481 U.S. at 54-56, and claims based on state insurance or unfair trade practices statutes, *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988) (as amended, 1989), *cert. denied*, 492 U.S. 906 (1989); *Anschultz v. Connecticut General Life Ins. Co.*, 850 F.2d 1467, 1469 (11th Cir. 1988); *Hogan v. Kraft Foods*, 969 F.2d 142 (5th Cir. 1992).

("NMHPA").[16] In passing the reforms, Congress noted that "the practices of employers and insurers with respect to the administration of group health plans are of considerable significance to *all* workers and their families." H.R. REP. No. 496, 104th Cong., 2d Sess. 1871 (1996) (emphasis added). Indeed, Congress *premised* the reform amendments on the fact that private sector "garden variety" group health care plans are ERISA-covered. The legislative history explains that "[ERISA] imposes Federal requirements on *most* employer-sponsored health plans. *Exempt* from ERISA are health benefit plans that are provided by Federal, State and local governments, churches and certain educational organization plans." *Id.* at 1874 (emphasis added). Congress' choice of ERISA amendments to accomplish health care reform is not inadvertent; as it did in passing COBRA, Congress used the existing "employee benefit plan" concept to *expand* the realm of federal laws granting worker protections.[17]

Review of the Arizona Court of Appeals' decision is essential to clarify to the lower state and federal courts Congress' intent that federal law under ERISA provide "nationally uniform administration," *Travelers*, 115 S.Ct. at 1677-78, and "exclusive" civil enforcement remedies for

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[16] These three reform statutes are tied into ERISA § 3(1)'s definition of "employee welfare benefit plan" pursuant to ERISA section 733(a)(1), 29 U.S.C. § 1191b(a)(1). This section defines a "group health plan" as "an employee welfare benefit plan to the extent that the plan provides medical care" as defined in section 733(a)(2), 29 U.S.C. § 1191b(a)(2), which includes "amounts paid for—(A) the diagnosis, cure, mitigation, treatment or prevention of disease."

[17] The COBRA rules apply to employers which normally employ at least 20 employees per year, see 29 U.S.C. § 1161(b); HIPAA applies to employers with at least two employees, see 29 U.S.C. § 1191a(a); MHPA applies to employers with at least 50 employees, see 29 U.S.C. § 1185a(c)(1); and NMHPA applies to employers with at least two employees, see 29 U.S.C. § 1191a(a). As indicated above, the Arizona ruling and the principle on which it rests are *not* limited to small or mid-sized employers; they cover *all* employers regardless of size.

*all* employee welfare benefit plans, self-funded and insured alike, *Pilot Life*, 481 U.S. at 52. The decision below is not only at odds with ERISA's carefully crafted regulatory framework and the important principles of uniformity on which it is based; it frustrates Congress' goal of "eliminating the threat of conflicting or inconsistent State or local regulation ef employee benefit plans,'" *Travelers*, 115 S.Ct. at 1677 (citation omitted), at the dawn of significant national health care reform.

As discussed in more detail in Section IV, *infra*, the questions presented by this petition hold important implications for federal versus state regulation of insured health care plans that should be addressed by this Court. The United States has a *voluntary* system of employee benefit plans which is fostered, in large measure, by the protections of a uniform system of remedial federal law. Many of these plans, moreover, are multi-state in operation. Millions of employees and dependents enjoy protections under health care arrangements similar to those established by Prescott Glass.[18] These are *efficient* "off the shelf" products funded through insurance and administered by insurance companies. The overwhelming majority of these plans are established by employers such as Prescott Glass *simply* through the purchase of group insurance, with employer involvement generally limited to selecting the benefits, enrolling participants, and in many cases, paying some or all of the premiums.[19] Far from requiring that plan administration be performed by the employer, ERISA expressly authorizes the allocation of *all* administrative duties without affecting coverage, *see* ERISA § 405(c)(1), 29 U.S.C. § 1105(c)(1), and the Department of Labor regulations contemplate that an insurer may perform

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[18] STATISTICAL ABSTRACT OF THE UNITED STATES 118 (115th ed. 1995). Of the 182.4 million covered by private sector health insurance, individual or group, 148.3 million are covered by *employment-related* group health insurance. *Id.*

[19] Scallet, *The Regulation of Multiple Employer Trusts: Past, Present & Future*, 61 WASH. U.L.Q. 359, 381 (1983) [*hereinafter Regulation of METs*].

claims processing and serve as claims review fiduciary. *See* 29 C.F.R. § 2560.503-1(g)(2). Indeed, it is extremely common for employers not to play any active role in the administration of such plans; professional plan administration is one of the services employers seek to purchase from insurance carriers. The administration for the overwhelming majority of these plans—91%—is conducted *not* by the employer, but rather by commercial insurers, Blue Cross/Blue Shield plans or third-party administrators.[20]

All parties—employers, participants, beneficiaries, insurers, Blue Cross/Blue Shield plans and third-party administrators—need *certainty* on whether ERISA or state law will govern group health care plans. If allowed to stand, the decision below, and similar decisions, discussed *infra*, will continue to cause unnecessary and extraordinary confusion and difficulty. The detrimental impact would be the greatest for smaller and mid-sized employers who buy "off the shelf" health care plans funded and administered by insurance companies or Blue Cross/Blue Shield plans. These employers generally do not have the trained staff, the capability or the time to administer their own benefit plans, and their administrative expenses would be exorbitantly high.[21] The decisions will lead to an even greater increase in suits motivated by the lure of punitive damage awards, which ultimately will add to the cost of health insurance and cause employers to decrease benefit levels or not to sponsor plans at all. *Fort Halifax*, 482 U.S. at 13. They will cause an immediate decrease in participant rights and protections, including not only ERISA fiduciary standards, reporting and disclosure pro-

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[20] 1996 FOSTER HIGGINS SURVEY, *supra* note 2, at 18-19; *Regulation of METS*, *supra* note 19, at 381; BATELLE STUDY, *supra* note 14, at 43.

[21] *See* O. Mitchell & E. Andrews, *Scale Economics in Private Multi-Employer Pension Systems*, 34 INDUS. & LABOR RELATIONS L. REV. 522, 527 (1981) (administrative expenses per participant for plans with 100 employees exceed tenfold those of plans with 20,000 members).

tections, and civil and criminal enforcement mechanisms, but COBRA rights and the evolving national health care reforms enacted through ERISA amendments.

ERISA coverage and regulation of insured health care plans therefore require clarification by this Court in light of the sharp conflict in decisions and the increasingly unsettled body of law in the lower courts. This Court has addressed the subject of what is *excluded* from ERISA in terms of severance and vacation pay;[22] similarly, it has upheld ERISA preemption and the exclusivity of its civil enforcement provisions in insurance claims processing disputes on the assumption the plan was ERISA-covered.[23] It has not yet ruled on the increasingly significant issue of the *essential elements* required for ERISA plan coverage.

The definition of an ERISA "employee benefit plan"—whether health care or otherwise—is the most basic building block for the statutory scheme. Nevertheless, this threshold issue has caused continual confusion and difficulty for the lower courts in an area where uniformity of law should prevail. The Arizona decision is only the most recent in a number of state and federal court decisions (*see* citations in Section III, *infra*) that seek to nullify ERISA's regulation of insured health care plans by labeling them "non-ERISA covered." This unfortunate effort at resurrecting state law as the principal mechanism for regulating such plans contravenes this Court's holding in *Pilot Life, supra*. These decisions not only upset ERISA's careful balance between federal and state law, they also unintentionally serve as guideposts for employers to escape ERISA's civil and criminal enforcement mechanisms by simply asserting that the insurance carrier handles administration—something that is true of virtually *every*

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[22] *E.g., Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987) (state mandated one-time severance pay benefits requiring no ongoing administrative scheme *excluded* from ERISA as not being a "plan"); *Massachusetts v. Morash*, 490 U.S. 107 (1989) (unfunded vacation pay plans paying benefits out of the employer's general assets *excluded* from ERISA as a payroll practice).

[23] *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

insured plan. Furthermore, Congress' health care reform efforts are premised on ERISA's definition of "employee welfare benefit plan," and thus heavily depend on the "garden variety" plans labeled "non-ERISA" by these courts. Unless the decision below is reversed, two of Congress' most important goals in enacting ERISA—broad plan coverage and national uniformity of regulation—will be seriously eroded. This Court therefore should resolve the classic conflict between state and federal law created by the Arizona decision (and others like it) and reaffirm the balance struck by Congress in ERISA.

## II. THE DECISION BELOW AND A GROWING NUMBER OF SIMILAR ONES REFUSE TO FOLLOW FEDERAL LAW, THEREBY EXCLUDING VIRTUALLY ALL INSURED HEALTH CARE PLANS FROM ERISA PROTECTIONS.

"ERISA's coverage is broad, and [its] exceptions are few and narrow." R. J. COOKE, ERISA PRACTICE & PROCEDURE § 2.01 (Shepard's/McGraw Hill 1994). ERISA section 3(1) expansively defines "employee welfare benefit plan" to include "*any* plan, fund, or program . . . established or maintained by an employer . . . providing . . . *medical*, surgical, or hospital care or benefits" "*through the purchase of insurance or otherwise.*" 29 U.S.C. § 1002(1) (emphasis added).[24] The Act's broad sweep also is evident from the fact that an ERISA plan need cover only *one* employee as long as the employer is engaged in an industry or activity affecting interstate commerce.[25] Congress, moreover, intended that even this

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[24] An "employee benefit plan" can also be established by an "employee organization" or by *both* an employer and an "employee organization." ERISA § 3(1), 29 U.S.C. § 1002(1).

[25] ERISA § 4(a), 29 U.S.C. § 1003(a). Unlike a number of federal statutes, ERISA provides for *expansive* employer coverage and does not require more than one common-law employee. ERISA § 3(1), 29 U.S.C. § 1002(1); *Williams v. Wright*, 927 F.2d 1540 (11th Cir. 1991); *Biggers v. Wittek Indus., Inc.*, 4 F.3d 291, 297 (4th Cir. 1993); DOL Op.Ltr. 77-10. ERISA's predecessor statute, the Welfare and Pension Plans Disclosure Act, Pub.L. No. 85-836, 72 Stat. 997, excluded plans covering less than 25 employees. Al-

broad "coverage . . . be construed liberally." [26]

Recognizing that cost-effective group insurance was essential to accomplishing its objectives, Congress carefully framed ERISA's definition of employee benefit plan to encompass *all* "employee welfare benefit plans," whether established "through the purchase of insurance or otherwise." ERISA § 3(1), 29 U.S.C. § 1002(1). The statute is replete with references to insurance funding and administration of employee benefits plans, signifying Congress' recognition of the critical role insurance plays in the employee benefits field. *See, e.g.*, ERISA §§ 102(b), 103(a)(2), 401(b)(2), 29 U.S.C. §§ 1022(b), 1023(a)(2), 1101(b)(2); *see also* 29 C.F.R. § 2560.503-1. In addition, Congress sought to impose federal fiduciary standards on both self-funded and insured plans, not only to ensure uniformity, but to make certain that "insured plans, which do not use the trust form as the mode of funding," would be subject to the same exacting standards.[27]

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though aware of this prior limitation, Congress determined not to include it in ERISA. *See* RETIREMENT INCOME SECURITY FOR EMPLOYEES ACT OF 1973, S. REP. NO. 127, 93d Cong., 1st Sess. 6 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4838, 4842-43. In contrast, Congress made Title VII of the Civil Rights Act of 1964 applicable only to employers with at least 15 employees, 42 U.S.C. § 2000e(b); it made the Age Discrimination in Employment Act applicable only to employers with 20 or more employees, 29 U.S.C. § 630; and it made the Americans with Disabilities Act applicable only to employers with 25 or more employees (the threshold fell to 15 on July 26, 1994), 42 U.S.C. § 12111(5)(A).

[26] RETIREMENT INCOME SECURITY FOR EMPLOYEES ACT OF 1973, S. REP. NO. 127, 93d Cong., 1st Sess. 18 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4838, 4854; EMPLOYEE BENEFIT SECURITY ACT OF 1973; H.R. REP. NO. 533, 93d Cong., 1st Sess. 18 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4656 (ERISA covers "all private employee benefit plans under Commerce Clause jurisdiction," with stated exceptions); *see also Blau v. Del Monte Corp.*, 748 F.2d 1348, 1352 (9th Cir. 1984) (as amended in 1985), *cert. denied*, 474 U.S. 865 (1985).

[27] EMPLOYEE BENEFIT SECURITY ACT OF 1973, H. R. REP. NO. 533, 93d Cong., 1st Sess. 12 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4650.

ERISA's plain language indicates that Congress intended to subject *all* employee benefit plans, including "garden variety" plans with funding and administration provided by insurance companies, to the same pervasive federal regulation. This is true regardless of whether the employer "intends" to establish an ERISA plan [28] or complies with the Act's reporting and disclosure requirements,[29] or whether the plan is contained in a written instrument.[30]

In *Marshall v. Bankers Life & Cas. Ins. Co.*, 2 Cal.4th 1045, 10 Cal.Rptr.2d 72, *cert. denied*, 506 U.S. 1000 (1992), the court examined a "garden variety" insured group health care plan identical to the one in the present case. It correctly held that an employer which "purchases a group [health] insurance policy, contributes towards premiums . . . and retains authority to terminate the policy . . . has 'established or maintained' an ERISA plan regardless of whether it also processes claims or otherwise administers the policy." 2 Cal.4th at 1057. The court added: "We conclude that an employee benefit plan is established on these facts despite the employer's *minimal* involvement in plan administration and *complete non-involvement* in claims processing." *Id.* at 1049 (emphasis added). Citing *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), it explained that ERISA "requires us to consider not the level of the *employer's* participation in an ongoing administrative program, but rather whether such a program exists at all." *Id.* at 1054. The court also cited to *Brundage-Peterson v. Compcare Health Services Ins. Co.*, 877 F.2d 509, 511 (7th Cir. 1989), in which

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[28] *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 107 (1983); *Donovan v. Dillingham*, 688 F.2d 1367, 1373 (11th Cir. 1982) (*en banc*); *Marshall v. Bankers Life & Cas. Ins. Co.*, 2 Cal. 4th 1045, 1057, 10 Cal. Rptr. 2d 72, *cert. denied*, 506 U.S. 1000 (1992).

[29] *Scott v. Gulf Oil Corp.*, 754 F.2d 1499 (9th Cir. 1985); *Blau v. Del Monte Corp.*, 748 F.2d 1348, 1352 (9th Cir. 1984) (as amended, 1985), *cert. denied*, 474 U.S. 865 (1985); *Marshall*, 2 Cal.4th at 1058 ("employer cannot 'opt out' of ERISA by non-compliance").

[30] *James v. National Business Systems, Inc.*, 924 F.2d 718, 720 (7th Cir. 1991).

Judge Posner wrote that "the contingent feature of a true welfare benefit plan . . . is unaffected by the delegation of the administration of the plan to an insurance company—a delegation contemplated by the statute." *Id.* at 1055.

The Arizona decision and its counterparts, by creating a coverage loophole for virtually all insured plans, would negate Congress' intent to impose national, uniform regulation on employee benefit plans, self-funded and insured alike. Under these decisions, an employer can evade the civil and criminal provisions of ERISA simply by arranging for an "off the shelf" group insurance plan administered by an insurance company or third-party administrator, or by purchasing coverage under a Blue Cross/Blue Shield plan.

The Arizona decision and similar ones thus produce a result exactly the *opposite* of what Congress mandated. Instead of requiring *employer* plan administration in each instance, ERISA coverage requires only very limited employer endorsement or conduct. As pointed out by the Ninth and Sixth Circuits, an employer can establish an ERISA plan *"rather easily,"* even if it "does no more than arrange for a *'group type insurance program'."* *Credit Managers Ass'n* v. *Kennesaw Life & Acc. Ins. Co.*, 809 F.2d 617, 625 (9th Cir. 1987) (emphasis added); *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489, 492 (9th Cir. 1988) (as amended, 1989), *cert. denied*, 492 U.S. 906 (1989); *Qualls v. Blue Cross of California, Inc.*, 22 F.3d 839, 843 (9th Cir. 1994); *International Resources, Inc. v. New York Life Ins. Co.*, 950 F.2d 294, 297-98 (6th Cir. 1991) (employer establishes ERISA plan "rather easily" where it chooses plan, pays premiums and provides coverage to only one employee other than the company president), *cert. denied*, 504 U.S. 973 (1992).

Only a two-step determination is required: (1) does an "employee benefit plan" exist which requires an ongoing administrative scheme, *Fort Halifax*, 482 U.S. 1,

and if so, (2) is the plan "established or maintained" by an employer as contemplated by ERISA section 3(1), 29 U.S.C. § 1002(1), *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982) (*en banc*). Under *Donovan*, a "plan" exists if " 'from the surrounding circumstances a reasonable person could ascertain [1] the intended benefits, [2] beneficiaries, [3] source of financing, and [4] procedures for receiving benefits.' " 688 F.2d at 1373. To be *ERISA-covered*, the plan must also satisfy the second-step, namely, it must be "established or maintained" by an employer. *Id.* The Prescott Glass Plan—which provided health insurance benefits selected, arranged and paid for by the employer, and required an ongoing administrative scheme handled by the insurance company—plainly met both of these very simple standards.

In addition, the Arizona decision and similar decisions challenge and throw into confusion the significance of the Department of Labor's "safe harbor" regulations which have been used as a "bright line" test for determining both the absence and the presence of ERISA coverage. The "safe harbor" regulations describe "certain insurance arrangements in which the *involvement* of the employer . . . is *sufficiently minimal* that it does *not* constitute *establishment or maintenance* . . . for purposes of section 3(1) of ERISA."[31] The regulations, by listing four specific criteria all of which must be met if a "group or a group type" insurance arrangement is to be ERISA-exempt, demonstrate that even the most *minimal* employer conduct or endorsement generates ERISA coverage.[32] The "safe harbor" opens *only* when:

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[31] DOL Op.Ltr. 94-26A (emphasis added); see 29 C.F.R. § 2510.3-1(j).

[32] For the employer to satisfy the "safe harbor" regulations and thus be outside of ERISA, there is a "basic requirement of employer neutrality and an absence of employer involvement." Department of Labor's Explanatory Statement, 40 FED. REG. 34526, 34527 (Aug. 15, 1975). *All four* "safe harbor" criteria must be met. *Kanne*, 867 F.2d at 493; *Qualls*, 22 F.3d at 843; *Sarraf v. Standard Ins. Co.*, 102 F.3d 991, 993 (9th Cir. 1996); *Memorial*

> (1) *No* contributions are made by an employer . . .;
>
> (2) Participation . . . is *completely voluntary* for employees . . .;
>
> (3) The sole functions of the employer . . . are, *without* endorsing the program, to permit the insurer to publicize the program to employees . . . [and] to collect premiums and to remit them to the insurer; and
>
> (4) The employer . . . receives *no* consideration . . . other than reasonable compensation . . . for administrative services actually rendered.[33]

As indicated above, the scope of ERISA plan coverage for insured health care plans—an increasingly *significant* issue that has confused and troubled many of the lower courts, as discussed in section III, *infra*—requires a timely resolution by this Court. The proper outlines for this

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*Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990); *Kidder v. H&B Marine, Inc.*, 932 F.2d 347, 351 (5th Cir. 1991); *Marshall*, 2 Cal.4th at 1055. The Department of Labor has ruled that a "group-type" insurance arrangement for employees falls outside of ERISA where the following occur: the purchase of individual policies is *completely voluntary* for employees; the employer does *not* endorse the program or encourage participation but simply permits the insurer to publicize it; the promotional literature clearly states that the employer does not endorse the program; the employer merely transmits premiums through payroll deductions; and only the payroll deductions and not the insurance coverage in the individual policies, cease upon the termination of employment. DOL Op.Ltr. 83-3A.

[33] 29 C.F.R. § 2510.3-1(j) (emphasis added). Prescott Glass did *not* satisfy any of the applicable criteria in the "safe harbor" regulations. The employer *contributed* the initial premiums and thereafter all monthly premiums for Hibma and Hull, *Qualls*, 22 F.3d at 843-44, *International Resources*, 950 F.2d at 298; the employer selected the plan without employee input on the type of coverage and enrolled *all* employees, and thus participation was not "completely voluntary," *Brundage-Peterson*, 877 F.2d at 511; and the employer plainly "*endorsed*" the plan by selecting the plan, enrolling all employees, and paying premiums, *Qualls*, 22 F.3d at 843-44; DOL Op.Ltr. 94-26A; *Randol v. Mid-West Nat. Life Ins. Co. of Tennessee*, 987 F.2d 1547, 1550-51 (11th Cir.), *cert. denied*, 510 U.S. 863 (1993). The fourth criterion was not applicable.

resolution, which petitioner urges this Court to adopt, emerge from Department of Labor Opinion Letters and the Seventh and Ninth Circuit decisions which have used the regulations for a *second* purpose—as a "bright line" test to determine whether the employer's level of involvement is sufficient to satisfy section 3(1)'s requirement that the plan be "established or maintained" by an employer and thus ERISA-covered.[34] This "bright line" test illustrates the extraordinary breadth of the statute which demonstrably picks up "garden variety" insured health care plans. Under the test, a plan is ERISA-covered if the sponsor does *any* of the following: creates a group insurance plan through a contract with an insurance company and designates which employees are eligible to enroll; contributes towards premiums; enrolls all eligible employees or agrees to minimum participation levels, thus making the coverage not "completely voluntary"; or "endorses" the plan by encouraging employee participation, holding the plan out as a "benefit of employment," or by engaging in plan administration (other than simply remitting payroll deductions to the insurer). *See* DOL Op.Ltr. 94-26A (where the sponsor "endorses" disability income plans, its "involvement . . . *exceeds* the minimal and neutral involvement contemplated by [the regulations]";

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[34] The Department of Labor correctly pointed out in the preface to the regulations that they do not indicate that *all* arrangements outside the "safe harbor" are ERISA plans. For example, a plan sponsored by a governmental entity would be outside of ERISA, see § 4(b)(1), 29 U.S.C. § 1003(b)(1), as would a plan covering only partners in a partnership, § 3(1), (6), § 1002(1), (6). It stated that the regulations do not give an exhaustive list of practices excluded from ERISA's definition of "welfare" plan; that the regulations include some plainly excluded practices such as payroll practices, on-premises facilities, holiday gifts, etc.; and that they mention some general categories of excluded practices in response to questions the Department had received, which, in its judgment, do not represent *borderline cases* of ERISA plans. 29 C.F.R. § 2510.3-1 (a)(4). As shown by the Opinion Letters cited above, the Department considers *welfare* plans to be ERISA-covered if the plan requires an ongoing administrative scheme and the sponsor's involvement *exceeds* the minimum level prescribed by the regulations.

accordingly, the plans are "*established or maintained*" by the sponsor and are therefore "*employee welfare benefit plans subject to Title I of ERISA*") (emphasis added); DOL Op.Ltr. 82-9A; *Qualls*, 22 F.3d at 843 (employer premium payment makes a plan ERISA-covered; "unless [the regulations] are met, the employer's involvement . . . is sufficient to constitute an 'employee benefit plan' subject to ERISA"); D. BACON, S. PRATER, D. TUCKER, EMPLOYEE BENEFITS GUIDE § 2.02[3] (Matthew Bender & Co. 1996); *Brundage-Peterson*, 877 F.2d 511 (an insured welfare plan is ERISA-covered regardless of who pays the premiums where the employer is *involved in the selection of plans* and thus the plan is not "completely voluntary").

The Arizona decision and similar ones upend Congress' goal of "nationally uniform administration of employee benefit plans," *Travelers*, 115 S.Ct. at 1677-78, by *excluding* "garden variety" insured group health care plans—the backbone of the nation's health care system. Significantly, this exclusion is not only from ERISA's fiduciary standards, and its civil and criminal enforcement provisions, but also from COBRA and the national health care reform amendments, results contrary to everything that Congress intended in the "massive undertaking of ERISA," *Pilot Life*, 481 U.S. at 44. Intervention by this Court is necessary to restore the primacy of federal law in this area of significant public interest.

## III. THE DECISION BELOW IS ONE OF A GROWING MINORITY OF STATE AND FEDERAL COURT DECISIONS THAT CONFLICT WITH THE MAJORITY RULE DEVELOPED IN THE FEDERAL CIRCUITS.

Review of the Arizona decision is essential to end the conflict and confusion in ERISA's plan coverage jurisprudence as the lower courts seek to avoid the uniformity of federal law and remedies mandated by Congress and recognized in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). Employers, insurers, Blue Cross/Blue Shield

plans and third-party administrators must be able to make responsible planning decisions.

The Arizona court is but one of many state courts to express its dissatisfaction with the choices Congress made in resolving the "innumerable disputes between powerful competing interests—not all in favor of potential plaintiffs." *Mertens v. Hewitt Associates,* 508 U.S. 248, 262 (1993). State appeals courts using similar reasoning, and thus excluding from ERISA coverage "off the shelf" welfare plans with insurance company funding and administration, include, to name a few, *Peters v. Boulder Ins. Agency, Inc.,* 829 P.2d 429 (Colo. Ct. App. 1991), *cert. denied,* 1992 Colo. LEXIS 332; *Blue Cross/Blue Shield of Florida, Inc. v. Weiner,* 543 So.2d 794 (Fla. Ct. App.), *review denied,* 553 So.2d 1164 (Fla. 1989), *cert. denied,* 494 U.S. 1028 (1990), *aff'd by abstention in collateral proceeding,* 730 F. Supp. 674 (D. Md. 1990), *aff'd,* 925 F.2d 81 (4th Cir.), *cert. denied,* 502 U.S. 816 (1991); *Jeanette M. v. Blue Cross/Blue Shield of Louisiana,* 662 So.2d 498 (La. App. 1995), *cert. denied,* 667 So.2d 1054 (La. 1996); and *Robertson v. Gem Ins. Co.,* 828 P.2d 496 (Utah Ct. App. 1992).[35] These decisions all share the fundamental misperception that ERISA coverage depends not on the statutory definition in section 3(1) but on how a plan is funded or administered, notwithstanding that ERISA gives an employer *multiple* funding and administration options—including the purchase of insurance and performance of all administrative duties by others—without in any way affecting coverage. *See Regulation of METs, supra* note 19, at 387-88. The reasoning of these courts is based on an outdated pair of

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[35] *See also Sayble v. Blue Cross of Southern Calif.,* 256 Cal.Rptr. 820 (1989), *overruled by Marshall v. Bankers Life & Cas. Ins. Co.,* 2 Cal.4th 1045, 10 Cal.Rptr.2d 72, *cert. denied,* 506 U.S. 1000 (1992), and *Turnbow v. Pacific Mut. Life Ins. Co.,* 765 P.2d 1160 (Nev. 1988), *cert. denied,* 490 U.S. 1102 (1989), *limited in Villescas v. CNA Ins. Cos.,* 864 P.2d 288 (Nev. 1993).

cases that no longer retain vitality in their own Circuits.[36] *All* of these decisions conflict with the plain meaning of ERISA's definition of "employee welfare benefit plan," the law in the majority of the Circuits,[37] and with the long-held views and the "safe harbor" regulation of the Department of Labor.[38] The serious lack of uniformity and the growing uncertainty created by these rulings, which seek to reassert state law control and remedies in an area which is " 'exclusively a federal concern,' " *Pilot Life*, 481 U.S. at 45-46 (citation omitted), provide sufficient grounds for reviewing the Arizona decision.[39]

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[36] *See Wayne Chemical, Inc. v. Columbus Agency Service Corp.*, 567 F.2d 692, 699 (7th Cir. 1977); *Taggart Corp. v. Life & Health Benefits Admin. Inc.*, 617 F.2d 1208 (5th Cir. 1980), *cert. denied*, 450 U.S. 1030 (1981); *see also Jordan v. Reliable Life Ins. Co.*, 694 F.Supp. 882, 835 (N.D. Ala. 1988) (rejecting ERISA coverage and preemption as overly burdensome: "Only Congress or the Supreme Court can rescue us from the quicksand").

[37] *Grimo v. Blue Cross/Blue Shield of Vermont*, 34 F.3d 148 (2d Cir. 1994); *Madonia v. Blue Cross & Blue Shield of Virginia*, 11 F.3d 444 (4th Cir. 1993), *cert. denied*, 114 S.Ct. 1401 (1994); *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990); *Fugarino v. Hartford Life & Acc. Ins. Co.*, 969 F.2d 178 (6th Cir. 1992), *cert. denied*, 506 U.S. 893 (1993); *Brundage-Peterson*, 877 F.2d 509; *Kanne*, 867 F.2d 489; *Qualls*, 22 F.3d 839; *Roe v. General Am. Life Ins. Co.*, 712 F.2d 450 (10th Cir. 1983); *Donovan v. Dillingham*, 688 F.2d 1367; *Sofo*, 13 F.3d 239; *Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277 (11th Cir. 1987). *But see Johnson v. Watts Regulator Co.*, 63 F.3d 1129 (1st Cir. 1995).

[38] 29 C.F.R. § 2510.3-1(j); DOL Op.Ltr. 77-54.

[39] State courts have pursued purely local interests at the expense of national uniformity in areas closely related to ERISA plan coverage and civil enforcement, as well. For example, the Alabama Supreme Court, contrary to this Court's rulings in *Pilot Life*, 481 U.S. 41; *Mertens*, 508 U.S. 248, and *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985), and in direct conflict with every Circuit Court of Appeals to have considered the issue, repeatedly has held that ERISA authorizes *punitive damages*. *Compare In re Metropolitan Life Ins. Co.*, 679 So.2d 686 (Ala. 1996), *Weems v. Jefferson-Pilot Life Ins. Co.*, 663 So.2d 905 (Ala.) *cert.*

## IV. THE QUESTIONS PRESENTED DIRECTLY IMPACT EMPLOYERS NATIONWIDE AND OVER 140 MILLION INDIVIDUALS COVERED BY GROUP HEALTH INSURANCE.

Unless reversed, the decision below—and similar ones described above—will have a significant adverse impact on (literally) millions of insured employee benefit plans across the country. The Department of Labor indicates that in the United States there are an estimated 4.5

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*denied*, 116 S.Ct. 434 (1995), *and Haywood v. Russell Corp.*, 584 So.2d 1291 (Ala. 1991), with *Drinkwater v. Metropolitan Life Ins. Co.*, 846 F.2d 821 (1st Cir.) *cert. denied*, 488 U.S. 909 (1988); *Powell v. Chesapeake & Potomac Tel. Co. of Virginia*, 780 F.2d 419, 424 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986); *Medina v. Anthem Life Ins. Co.*, 983 F.2d 29 (5th Cir.), *cert. denied*, 510 U.S. 816 (1993); *Varhola v. Doe*, 820 F.2d 809 (6th Cir. 1987); *Kleinhans v. Lisle Sav. Profit Sharing Trust*, 810 F.2d 618, 627 (7th Cir. 1987); *McRae v. Seafarers' Welfare Plan*, 920 F.2d 819, 821 (11th Cir. 1991); *Harsch v. Eisenberg*, 956 F.2d 651 (7th Cir.), *cert. denied sub nom. Bihler v. Eisenberg*, 506 U.S. 818 (1992); *Lafoy v. HMO Colorado*, 988 F.2d 97 (10th Cir. 1993); *Dependahl v. Falstaff Brewing Corp.*, 653 F.2d 1208, 1216 (8th Cir.), *cert. denied*, 454 U.S. 968 (1981); *Johnson v. District 2 Marine Eng'g Beneficial Ass'n*, 857 F.2d 514 (9th Cir. 1988); *Sokol v. Bernstein*, 803 F.2d 532 (9th Cir. 1986); *Hancock v. Montgomery Ward Long-Term Disability Trust*, 787 F.2d 1302, 1307 (9th Cir. 1986). The Alabama Supreme Court also has repeatedly held, in direct conflict with every Circuit Court of Appeals to have considered the issue, that ERISA authorizes *jury trials. Compare In re Metropolitan Life Ins. Co.*, 679 So.2d at 688-89, and *Weems*, 663 So.2d at 914, *with Sullivan v. LTV Aerospace & Defense Co.*, 82 F.3d 1251 (2d Cir. 1996); *Pane v. RCA Corp.*, 868 F.2d 631 (3d Cir. 1989); *Berry v. Ciba-Geigy Corp.*, 761 F.2d 1003 (4th Cir. 1985); *Borst v. Chevron Corp.*, 36 F.3d 1308 (5th Cir. 1994), *cert. denied*, 115 S.Ct. 1699 (1995); *Daniel v. Eaton Corp.*, 839 F.2d 263 (6th Cir.), *cert. denied*, 488 U.S. 826 (1988); *Sofo v. Pan-American Life Ins. Co.*, 13 F.3d 239 (7th Cir. 1994); *Kirk v. Provident Life & Accident Ins. Co.*, 942 F.2d 504 (8th Cir. 1991); *Nevill v. Shell Oil Co.*, 835 F.2d 209 (9th Cir. 1987); *Spinelli v. Gaughan*, 12 F.3d 853 (9th Cir. 1993); *and Blake v. Union-Mutual Stock Life Ins. Co. of Am.*, 906 F.2d 1525 (11th Cir. 1990).

million employer-sponsored health care plans.[40] Overwhelming percentages of these plans are insured.[41] Many of these plans are multi-state in operation. In addition, more than 9 out of 10 *delegate* administration to commercial insurers, Blue Cross/Blue Shield plans or third party administrators.[42] These insured plans—the core of the American private sector health care system—are the "garden variety" plans which the Arizona court deliberately *excluded* from ERISA's comprehensive regulation.

The threat of state law liability, including possible punitive damages, will seriously disrupt the voluntary system of employee benefit plans that Congress considered so essential. The decision's practical effect will be to void ERISA's carefully crafted fiduciary conduct and enforcement schemes whenever an employer purchases an efficient, "off the shelf" package of insurance company funding and administration or signs a contract with a Blue Cross/Blue Shield plan. The decision will shift responsibility for policing a large portion of the employee benefit plan system back to the states—a *replication* of the " 'conflicting or inconsistent State and local regulation' " that Congress intended to eliminate when it enacted ERISA. *Travelers*, 115 S.Ct. at 1677-78. Faced with the unavailability of punitive damages under ERISA, participants will have no incentive to pursue their federal rights, but will file state law extracontractual claims which will "pose an obstacle to the purposes and objectives of Congress" in enacting ERISA. *Pilot Life*, 481 U.S. at 52.

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[40] ADMINISTRATION OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT, REPORT OF THE SECRETARY OF LABOR TO CONGRESS at *i* (1987).

[41] 1996 FOSTER HIGGINS SURVEY, *supra* note 2, at 18. Eighty-six percent of employer health care plans are insured or are self-funded with stop-loss insurance coverage; the percentages are even higher for small employer health care plans (fewer than 100 employees) —99%. BATELLE STUDY, *supra* note 14, at 44

[42] 1996 FOSTER HIGGINS SURVEY, *supra* note 2, at 18-19.

The possibility of large damage awards not only will cause fiduciaries to make decisions intended to avoid state law liability, rather than decisions that are consistent with the fiduciary duties under ERISA, but may even deter a number of qualified persons from serving as fiduciaries. It will also result in increased insurance premiums and Blue Cross/Blue Shield fees to cover the additional litigation exposure. In turn, the additional transaction costs will cause employers to reduce the level of benefits or stop offering employee benefit plans altogether, *Fort Halifax*, 482 U.S. at 13, all of which conflicts with the "public interest in encouraging the formation of employee benefit plans," *Pilot Life*, 481 U.S. at 54.

A disposition by this Court, accordingly, will be necessary to provide practical guidance to employers, participants, beneficiaries, insurers, Blue Cross/Blue Shield plans and third-party administrators on the *necessary elements* for ERISA coverage of insured employee welfare benefit plans, as well as on the respective rights and responsibilities of all the parties. Additionally, intervention by this Court is essential to restore the carefully crafted balance between federal and state law struck by Congress in ERISA nearly a quarter of a century ago, a balance of increasing interest as Congress continues its enactment of national health care reform through ERISA amendments.

## CONCLUSION

For the foregoing reasons, petitioner urges the Court to grant certiorari in this case.

Respectfully submitted,

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March 17, 1997

# APPENDIX

# APPENDIX

## APPENDIX

[Filed May 21, 1996]

IN THE COURT OF APPEALS
STATE OF ARIZONA
DIVISION ONE

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1 CA-CV 94-0417
DEPARTMENT D

MICHAEL HIBMA, a single man; ROBERT HIBMA and SHARON HIBMA, husband and wife, on their own behalf and guardians and next friend of MICHELLE HIBMA, a minor; PRESCOTT GLASS COMPANY, a corporation,
*Plaintiffs-Appellees,*

v.

ALLSTATE LIFE INSURANCE COMPANY, an Illinois corporation,
*Defendant-Appellant.*

---

Appeal from the Superior Court of Maricopa County

Cause No. CV 90-11325

The Honorable William T. Moroney, Judge

AFFIRMED

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SUPPLEMENTAL MEMORANDUM DECISION

KLEINSCHMIDT, Judge

On March 14, 1996, we filed a memorandum decision in this case affirming the order of the trial court denying

Allstate Insurance Company's motion for summary judgment. The underlying question is whether ERISA preempts the Hibmas' state law claims arising out of Allstate's alleged breach of its health insurance contract. We were aware at the time we issued our decision that the parties had entered into a settlement agreement that called for Allstate to pay a higher amount if the Hibmas prevailed on appeal and a lower amount if Allstate prevailed. We were not aware of the details of the agreement, and did not realize that the settlement agreement would not be triggered by anything less than a decision on the merits of whether ERISA applied.

The decision that we issued did not turn on the merits. We found that whether Prescott Glass Corporation paid the premiums for its employee, Hull's, health insurance was an unresolved question of material fact. Since it was unresolved, we concluded the trial court had correctly denied the motion for summary judgment.

Both parties have now filed motions asking us to reconsider or clarify our decision. Allstate asks us to rule that ERISA applies if Prescott Glass did pay all or part of the premiums for Hull's insurance. The Hibmas, isolating some of the language from our decision, take the position that we did decide the case on the merits. As we have already noted, Allstate's characterization of our decision is correct.

We now decide the issue on the merits. We conclude that under the circumstances of this case, even assuming that Prescott Glass paid all or part of the premiums for Hull, ERISA does not apply. Hence, ERISA will not preclude the Hibmas' from pursuing their state law remedies. We adopt the reasoning of the Court of Appeals of Utah in *Robertson v. Gem Ins. Co.*, 828 P.2d 496 (Utah App. 1992):

> Existence of an employee benefit plan is a question of fact, to be determined by an objective standard, in light of all the pertinent circumstances and the

purposes sought to be served by ERISA. The extent of employer involvement in the administration and maintenance of the plan is of critical importance. The bare contribution of premiums to cover insurance purchased is not enough to establish an employee benefit plan. Congress intended to protect beneficiaries of plans by requiring disclosure, reporting, and specified standards of responsibility, and to avoid inconsistencies in administration requirements. Consideration should be given to the factors set forth in the Department of Labor regulations, but finding of any one factor is not determinative.

* * * *

The line between an ERISA plan and a non-ERISA plan depends to some extent on the level of employer involvement that would justify federal regulation of plan administration. *Rizzi,* 253 Cal. Rptr. at 547. Congressional policy, as expressed in ERISA, "recognizes the proliferation of employee benefit plans, certain abuses resulting in employee loss of [plan] benefits, and the need for Congress to establish certain minimal standards to assure 'the equitable character of such plans and their financial soundness.' " *Sayble,* 256 Cal. Rptr. at 823 (quoting 29 U.S.C. § 1001(a)). If there is no potential for "employer abuses such as self-dealing, imprudent investing, and misappropriation of plan funds," the aims of ERISA are not at stake. We also note the admonition in the *Sayble* decision:

"Respondents in effect argue the mere payment by an employer of premiums for employee health insurance is sufficient to constitute a plan governed by ERISA. Were that the case, every garden variety employee health insurance benefit would subject the paying employer, large or small, to ERISA's regulatory burdens, and would bind the insured to ERISA's remedies.

> However, where an obligation generates no administrative activity potentially subject to employer abuse, the regulatory concerns of ERISA are not implicated."

*Id.* at 502-03.

On the record as it most strongly favors Allstate in this case, we can say that the regulatory concerns of ERISA are not implicated. The order of the trial court is affirmed, and under the terms of the agreement entered into between the parties, the Hibmas are entitled to payment of the greater amount called for by the agreement.

/s/ Thomas C. Kleinschmidt
THOMAS C. KLEINSCHMIDT
Judge

CONCURRING:

/s/ Cecil B. Patterson, Jr.
CECIL B. PATTERSON, JR.
Presiding Judge
Department D

/s/ William F. Garbarino
WILLIAM F. GARBARINO
Judge

[Filed May 21, 1996]

IN THE COURT OF APPEALS
STATE OF ARIZONA
DIVISION ONE

---

1 CA-CV 94-0417
DEPARTMENT D

---

MICHAEL HIBMA, a single man; ROBERT HIBMA and SHARON HIBMA, husband and wife, on their own behalf and guardians and next friend of MICHELLE HIBMA, a minor; PRESCOTT GLASS COMPANY, a corporation,
*Plaintiffs-Appellees,*

v.

ALLSTATE LIFE INSURANCE COMPANY,
an Illinois corporation,
*Defendant-Appellant.*

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MARICOPA County Superior Court
No. CV 90-11325

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ORDER

The above-mentioned matter was duly submitted to the Court. The Court has this day rendered its Supplemental Memorandum Decision.

IT IS ORDERED that the Supplemental Memorandum Decision be filed by the Clerk.

IT IS FURTHER ORDERED that a copy of this Order, together with a copy of the Supplemental Memorandum Decision, be sent to each party appearing herein or to the attorney for such party, and to the Honorable William T. Moronay, Judge.

DATED this 21st day of May, 1996.

/s/ Thomas C. Kleinschmidt
THOMAS C. KLEINSCHMIDT
Judge

[Filed Mar. 14, 1996]

IN THE COURT OF APPEALS
STATE OF ARIZONA
DIVISION ONE

---

1 CA-CV 94 0417
DEPARTMENT D

MICHAEL HIBMA, a single man; ROBERT HIBMA and SHARON HIBMA, husband and wife, on their own behalf and guardians and next friend of MICHELLE HIBMA, a minor; PRESCOTT GLASS COMPANY, a corporation,
*Plaintiffs-Appellees,*

v.

ALLSTATE LIFE INSURANCE COMPANY,
an Illinois corporation,
*Defendant-Appellant.*

---

Appeal from the Superior Court of Maricopa County

Cause No. CV 90-11325

The Honorable William T. Moroney, Judge

AFFIRMED

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## MEMORANDUM DECISION

KLEINSCHMIDT, Judge

The question on appeal in this case is whether the federal Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461, preempts the Hibma's state law claims against the Appellant, Allstate Life Insurance Company. The claims are preempted if the Hibmas were insured under an "employee benefit welfare plan" as defined in the Act. Because that question turns on an unresolved issue of fact, the trial court correctly denied Allstate's motion for summary judgment. We therefore affirm that denial.

### *FACTS AND PROCEDURAL HISTORY*

Robert and Sharon Hibma own a small company, Prescott Glass Corporation. In 1987, Robert Hibma obtained group health insurance from Allstate for his family and for Prescott Glass's only other employee, Richard Hull. In 1988, Hibma's son Michael was permanently and severely injured in an accident, and he requires ongoing treatment. In 1989, Allstate notified all policyholders that it was terminating its health insurance program effective May 1, 1989.

The Hibmas and Prescott Glass sued Allstate for damages resulting from Allstate's failure to provide medical benefits to Michael. They asked for contract damages, additional damages alleged to have resulted from a lack of medical treatment, and punitive damages. In its answer, Allstate alleged ERISA preemption as an affirmative defense.

The parties filed cross motions for summary judgment. Allstate argued that it was entitled to terminate benefits under the policy. The plaintiffs countered this, claiming that they were entitled to partial summary judgment on their contract claim. The trial court denied Allstate's

motion and granted summary judgment to the plaintiffs on their claim for breach of contract.

Upon the close of discovery, Allstate filed another motion for summary judgment in which it claimed that ERISA preempted the plaintiff's remaining claims. The trial court denied this motion without comment. Allstate filed a special action contesting this ruling. While that was pending, and just prior to the time trial was to begin, the parties entered into a settlement agreement contingent on our decision on the merits of the preemption issue, whether that decision was reached in the special action or on an appeal. Specifically, the parties stipulated to a high-low figure contingent upon our resolution of the preemption issue and waived all other appealable arguments. After we declined jurisdiction in the special action, the parties agreed to the entry of judgment for one dollar in favor of the plaintiffs for the purpose of bringing the preemption issue to this court on appeal.

## *ALLSTATE WAS NOT ENTITLED TO SUMMARY JUDGMENT ON THE ISSUE OF PREEMPTION*

ERISA applies to any "employee benefit plan," including any "employee welfare benefit plan" established or maintained by an employer engaged in commerce. 29 U.S.C. § 1003(a) and 29 U.S.C. § 1002(3). An "employee welfare benefit plan" is

> any plan, fund, or program . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment . . . .

19 [sic] U.S.C. § 1002(1). Whether a plan meets this definition is a question of fact, and the party seeking to invoke preemption has the burden of showing the existence of an ERISA plan. *Kanne v. Connecticut General Life Ins.*

*Co.*, 867 F.2d 489, 492 n.4 (9th Cir.), *cert. denied*, 492 U.S. 906 (1989).

The critical question is whether Prescott Glass "established or maintained" the plan. The fact that an employer purchases insurance that includes coverage for employees is not conclusive as to whether an ERISA plan has been created, but it may provide evidence that such is the case. *Donovan v. Dillingham*, 688 F.2d 1367, 1372 (11th Cir. 1982); *Scott v. Gulf Oil Corp.*, 754 F.2d 1499, 1503-04 (9th Cir. 1985).

The Plaintiffs claim that neither they nor the insurance company's agent intended to create an ERISA plan. The intent of the employer is, however, not determinative. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). The Act does not specify what is required to establish or maintain an ERISA plan, but the Department of Labor has adopted regulations which give guidance as to when an employer's participation is so minimal that ERISA does not apply:

> For purposes of title I of the Act and this chapter, the terms "employee welfare benefit plan" and "welfare plan" shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which
>
> (1) No contributions are made by an employer or employee organization;
>
> (2) Participation [in] the program is completely voluntary for employees or members,
>
> (3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and

> (4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.

29 C.F.R. § 2510.3-1(j). Under this regulation and cases which interpret the Act, an employer who is minimally involved with a health insurance plan offered to employees is not subject to ERISA. *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236, 240-41 (5th Cir. 1990); *Brundage-Peterson v. Compcare Health Services Ins. Corp.*, 877 F.2d 509, 510 (7th Cir. 1989). The language of the regulation indicates that all four criteria must be met to remove a plan from the purview of ERISA, and most of the court decisions acknowledge that such is the case. *See, e.g., Kanne*, 867 F.2d at 492-93; *Marshall v. Bankers Life and Casualty Co.*, 832 P.2d 573, 579 (Cal.), *cert. denied*, 506 U.S. 1000 (1992); *Eichner v. Celtic Life Ins. Co.*, 596 N.E.2d 1124, 1128 (Ohio App. 1991). In *Robertson v. Gem Ins. Co.*, 828 P.2d 496, 503 (Utah App. 1992), however, the Utah Court of Appeals said that while consideration should be given to the Department of Labor regulations, the absence of any one factor referred to in those regulations was not determinative. The *Robertson* court held that the trial court had erred in finding the existence of an ERISA plan based on the sole fact that the employer helped make arrangements for insurance for its employees.

During oral argument, the parties agreed that Allstate had issued a separate policy to Prescott Glass's employee, Hull. More important, although Robert Hibma testified that Prescott Glass paid the permium for Hull's coverage, Hull testified that he had paid the premium himself. Counsel for Allstate conceded that this issue was unresolved. He pointed out that the plaintiffs did not rely on that point in their opening brief and suggested that they

had therefore waived the argument. He also argued that it was not a material issue because, according to counsel, the only way preemption can be avoided in this case is if the insurance plan meets all of the factors listed in the Labor Department's regulation.

While the plaintiffs did not focus on this unresolved dispute of fact until oral argument on appeal, they have always maintained that Allstate failed to carry its burden of showing that the plaintiffs had created an ERISA plan. The question of who paid Hull's premium was unresolved when the trial judge ruled on Allstate's motion for summary judgment, and for all we know that may have been the reason for the ruling. Even if it was not, we will uphold the trial court's ruling if it was right for any reason. *See Earthworks Contracting, Ltd. v. Mendel-Allison Constr.*, 167 Ariz. 102, 109, 804 P.2d 831, 838 (App. 1990).

Assuming that Hull did pay for all or part of his own coverage, the only unfulfilled factor mentioned in the regulations is that the employer's role was not limited to allowing the insurance company to publicize its program to Hull. The difference between that and what happened here—Hibma's arranging for insurance and giving Hull the choice of whether he wanted it—is so negligible, so lacking in anything meaningful to the enforcement of ERISA policy, that preemption does not apply in this case. *See Robertson, supra.*

The order of the trial court denying summary judgment is affirmed.

/s/ Thomas C. Kleinschmidt
THOMAS C. KLEINSCHMIDT
Judge

CONCURRING:

/s/ Cecil B. Patterson, Jr.
CECIL B. PATTERSON, JR.
Presiding Judge
Department D

/s/ William F. Garbarino
WILLIAM F. GARBARINO
Judge

[Filed Mar. 14, 1996]

IN THE COURT OF APPEALS
STATE OF ARIZONA
DIVISION ONE

---

1 CA-CV 94-0417
DEPARTMENT D

MICHAEL HIBMA, a single man; ROBERT HIBMA and SHARON HIBMA, husband and wife, on their own behalf and guardians and next friend of MICHELLE HIBMA, a minor; PRESCOTT GLASS COMPANY, a corporation,
*Plaintiffs-Appellees,*

v.

ALLSTATE LIFE INSURANCE COMPANY,
an Illinois corporation,
*Defendant-Appellant.*

---

Maricopa County Superior Court
No. CV 90-11325

---

ORDER

The above-mentioned matter was duly submitted to the Court. The Court has this day rendered its Memorandum Decision.

IT IS ORDERED that the Memorandum Decision be filed by the Clerk.

IT IS FURTHER ORDERED that a copy of this Order, together with a copy of the Memorandum Decision,

be sent to each party appearing herein or to the attorney for such party, and to the Honorable William T. Moroney, Judge.

DATED this 14th day of March, 1996.

/s/ Thomas C. Kleinschmidt
THOMAS C. KLEINSCHMIDT
Judge

[Filed Jun. 13, 1996]

IN THE COURT OF APPEALS
STATE OF ARIZONA
DIVISION ONE

---

1 CA-CV 94-0417
DEPARTMENT D

---

MICHAEL HIBMA, a single man; ROBERT HIBMA and SHARON HIBMA, husband and wife, on their own behalf and guardians and next friend of MICHELLE HIBMA, a minor; PRESCOTT GLASS COMPANY, a corporation,
*Plaintiffs-Appellees,*

v.

ALLSTATE LIFE INSURANCE COMPANY,
an Illinois corporation,
*Defendant-Appellant.*

---

Maricopa County Superior Court
No. CV 90-11325

---

ORDER

Appellant's Motion for Reconsideration of Supplemental Opinion was considered by Judges Thomas C. Kleinschmidt, William P. Garbarino and Cecil B. Patterson, Jr.

IT IS ORDERED denying the Motion for Reconsideration of Supplemental Opinion.

DATED this 13th day of June, 1996.

/s/ Thomas C. Kleinschmidt
THOMAS C. KLEINSCHMIDT
Judge

[STATE SEAL]

SUPREME COURT
STATE OF ARIZONA

402 Arizona State Courts Building
1501 West Washington
Phoenix, Arizona 88007-3329

Telephone: (602) 342-9396

Noel K. Dessaint
Clerk of Court

Kathleen E. Kempley
Chief Deputy Clerk

December 19, 1996

RE: MICHAEL HIBMA/ROBERT HIBMA et ux/
MICHELLE HIBMA et al vs.
ALLSTATE LIFE INSURANCE COMPANY
Supreme Court No. CV-96-0421-PR
Court of Appeals No. 1 CA-CV 94-0417
Maricopa County No. CV 90-11325

GREETINGS:

The following action was taken by the Supreme Court of the State of Arizona on December 17, 1996, in regard to the above-referenced cause:

ORDERED: Petition for Review = DENIED.

Record returned to the Court of Appeals, Division One, Phoenix, this 19th day of December, 1996.

NOEL K. DESSAINT, Clerk

SUPERIOR COURT OF ARIZONA
MARICOPA COUNTY

3

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HON. WILLIAM T. MORONEY

January 14, 1994

No. CV 90-11325

MICHAEL HIBMA, *et al.*

v.

ALLSTATE INSURANCE CO.

---

8:45 a.m. This is the time set for hearing on Defendant's Motion for Summary Judgment. Plaintiffs, Michael Hibma, et al., are represented by counsel, Frank Verderame. Defendant, Allstate Insurance Co., is represented by counsel, David F. Gaona.

Court Reporter, Myra Smith-Williams, is present.

Argument having been heard on the Defendant's Motion for Summary Judgment,

IT IS ORDERED denying the Motion for Summary Judgment.

IT IS FURTHER ORDERED denying Plaintiffs' oral motion for sanctions.

The Court requests that motions in limine be filed as soon as possible. The Court will rule on the motions, if time permits, before trial. If necessary, the Court will

take the first morning of trial, or as long as needed, to rule on pending pretrial motions. The Court will not set expedited oral argument on any of the motions.

9:30 a.m. Matter concludes.

IT IS FURTHER ORDERED affirming trial set for February 7, 1994, at 10:00 a.m. in this division, a three week trial to a jury.

IN THE SUPERIOR COURT
OF THE STATE OF ARIZONA
IN AND FOR THE COUNTY OF MARICOPA

---

No. CV 90-11325

MICHAEL HIBMA, a single man, *et al.*,
*Plaintiffs,*

vs.

ALLSTATE LIFE INSURANCE COMPANY,
an Illinois corporation; *et al.*,
*Defendants.*

---

JUDGMENT

This matter came before the Court by virtue of the Plaintiffs' Complaint alleging breach of contract and a breach of the implied duty of good faith and fair dealing. The causes of action are alleged to have arisen out of the Defendant Allstate Life Insurance Company's handling of claims pursuant to a contract of insurance provided to Michael Hibma as a dependent of Robert Hibma under a group insurance contract provided by Allstate Life Insurance Company to Robert Hibma's employer, Prescott Glass Corporation.

On the 2nd day September, 1992, the trial court granted the Plaintiffs' Motion for Summary Judgment that Allstate breached its contract with the Plaintiffs. On the 14th day of January, 1994, the trial court denied Allstate Life Insurance Company's Motion for Summary Judgment on the issue of the application of the Employees Retirement Income and Security Act of 1974 [sic] ("ERISA"), and issues of federal preemption of existing state law claims. From that denial, the parties agree that judgment in this matter be entered in favor of the Plaintiffs and

against the Defendant in the amount of $1.00 and that each party is responsible for its own attorneys' fees and costs.

IT IS HEREBY ORDERED that pursuant to stipulation, judgment is granted in favor of the Plaintiffs and against the Defendant Allstate Life Insurance Company in the sum of $1.00. Each party is to bear its own costs and attorneys' fees. No just reason for delay exists and judgment should be entered as a matter of law.

DONE IN OPEN COURT this —— day of May, 1994.

WILLIAM T. MORONEY
Judge of the Superior Court
of Maricopa County

SUPERIOR COURT OF ARIZONA
MARICOPA COUNTY

---

HON. THOMAS DUNEVANT III

September 2, 1992

No. CV 90-11325

ROBERT HIBMA, *et al.*

v.

ALLSTATE INSURANCE COMPANY, *et al.*

---

This matter has been under advisement on Plaintiffs' Motion for Partial Summary Judgment re: breach of contract and Defendant Allstate Life's Motion for Summary Judgment. The Court has considered the memoranda, oral argument and relevant law finds:

1. The rights and benefits under the plan are governed by the certificate of coverage (insurance).

2. The certificate of coverage, group insurance certificate of amendments, and the booklet of benefits (i.e. entire contract) must be read as a whole in determining the meaning of the term "loss" as contained in the policy. Because the term "loss" is not defined in the policy the term must be given its ordinary meaning in the context of its customary usage. In other words, the insurance contract must be read as a whole in order to give a reasonable and harmonious meaning and effect to all its provisions. *Sparks v. Republic National Life Ins. Co.*, 132 Ariz. 529.

3. If there is an ambiguity in the insurance policy, it must be construed against the drafter, Allstate. *Sparks v. Republic National Life Ins. Co.*

4. The medical benefits and the termination provisions of the policy provide that medical benefits will be paid "for eligible expense incurred for an injury or sickness while insured" and that "the end of insurance will not affect any claim under Plaintiffs' [sic] medical insurance made for a loss that took place while the insurance was in force." On the one hand, those provisions may be construed to mean that the termination provision does not effect [sic] any claim made for a loss that has occurred during the covered period, even though the insurance contract is terminated. On the other hand, those provisions may be construed to mean that medical benefits will be paid for all eligible expenses incurred as a result of injury or sickness suffered while insured for any loss that occurred during the covered period, and that those expenses shall be paid only during the period in which the policy is in effect or extended under the terms and conditions of the policy. In order to adopt the latter interpretation, a loss must be defined as an expense being incurred. In order to adopt the former interpretation, a loss must be defined as an "accidental injury or sickness." Because the language of the policy is ambiguous, it must be construed against Allstate, the insurer which drafted the policy. *Sparks vs. Republic National Life Ins. Co.*

5. Allstate's interpretation of the policy is inconsistent with and contrary to the reasonable expectations of Plaintiffs and Allstate's agent, Robert Allen Lee. *Darner Motor Sales, Inc. v. Universal Underwriters Insurance Co.*, 140 Ariz 383.

6. There is no genuine issue of material fact that by failing to pay benefits for Michael Hibma's injury after Allstate terminated the policy, that Allstate has breached the insurance contract. Thus, Plaintiffs are entitled to summary judgment as a matter of law.

7. In light of the Court's findings above, the issue regarding whether or not Allstate has breached the contract by terminating the contract, need not be reached.

Therefore, IT IS ORDERED:

1. Denying Allstate Insurance Company's Motion for Summary Judgment.

2. Granting Plaintiffs' Motion for Partial Summary Judgment Re: Breach of Contract.

[Dated November 15, 1993]

IN THE SUPERIOR COURT
OF THE STATE OF ARIZONA
IN AND FOR THE COUNTY OF MARICOPA

---

No. CV 90-11325

MICHAEL HIBMA, a single man, *et al.*,
*Plaintiff,*

vs.

ALLSTATE INSURANCE COMPANY,
an Illinois corporation, *et al.*,
*Defendants.*

---

ALLSTATE LIFE'S STATEMENT OF FACTS
IN SUPPORT OF ITS MOTION FOR
SUMMARY JUDGMENT

(Assigned to the Hon. William T. Moroney)

Defendant Allstate Life Insurance Company, pursuant to Rule IV(f), *Uniform Rules of Practice in the Superior Court*, submits its Statement of Facts in Support of its Motion for Summary Judgment as follows:

1. In the spring of 1987, Robert and Sharon Hibma, acting on behalf of Prescott Glass Corporation, sought and obtained health insurance for the employees of Prescott Glass through Allstate Life Insurance Company. (Allstate Life's Rule 26.1 Disclosure Statement, p. 1; Deposition of Robert Hibma, dated June 25, 1993, pp. 52-53, atached hereto and incorporated by this reference).

2. Mr. Hibma, as the President of Prescott Glass Corporation, sought major medical health insurance for himself and his employees. (Deposition of Robert Hibma, June 25, 1993, p. 53, attached hereto and incorporated by this reference).

3. It was Mr. Hibma's intent to cover himself and another employee, who at that time was Mr. Hull, and, the providing of health insurance through Allstate Life was to be a benefit to the employees of Prescott Glass' employee. (Deposition of Robert Hibma, June 25, 1993, p. 60; Allstate Life billing invoice indicating the employees of the Allstate Life plan, Robert Hibma and Richard Hull, attached hereto as Exhibit 1).

4. Mr. Hibma, on behalf of Prescott Glass, made application to Allstate Life for major medical health care on behalf of the employees of Prescott Glass, an application was prepared and coverage issued, effective April 1, 1987. (Letter to Bob Lee from Allstate Life concerning Prescott Glass Corporation's effective date, attached hereto as Exhibit 2).

5. Following acceptance by Allstate Life of the Prescott Glass group, Mr. Lee, Allstate Life's field agent, delivered to Mr. Hibma the package of plan documents including booklets identifying the contents of the medical insurance plan, claim forms and claim envelopes. (Deposition of Robert Allen Lee, dated June 25, 1990, pp. 22-23).

6. Plaintiff Michael Hibma was a covered dependent of Robert Hibma, an employee of Prescott Glass Corporation, under the health insurance plan issued to Prescott Glass Corporation. (Declaration page and copy of Certificate of Insurance issued by Allstate Life to Prescott Glass Corporation, previously attached to Cross-Motions for Summary Judgment filed with this Court).

Respectfully submitted this 15th day of November, 1993.

GAONA & HAYNES, P.C.

By /s/ David F. Gaona
DAVID F. GAONA
3101 North Central Ave., Suite 720
Phoenix, Arizona 85012
Attorneys for Defendant
Allstate Life Insurance Company

Allstate Group Insurance
P.O. Box 727
Northbrook, Illinois 60062

See dec 20
& 1-B

'se pay exact amount shown., Re-
changes on appropriate form as
'n in Employer's Manual. Neces-
adjustments will appear on the
. statement.

| | Account No. | Total Paymen |
|---|---|---|
| 2 | 64121789 | 8436.4 |

| | Billing Period | | Billing Da |
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| | 03/01 | 03/31 | 02/15/ |
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PRESCOTT GLASS CORP.

208 E. SHELDON ST
PRESCOTT AZ 86301

Due Date
03/01/8

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| Certificate No. | Name of Employee | | Coverage Eff. Date (Mo./Day/Yr.) | Coverage Code ① | Age | Adj. Code ② | Mos. of Adj. | Life Ins. Amount | W.I. Amount | Employee Monthly Cost |
|---|---|---|---|---|---|---|---|---|---|---|
| 526808837 | HULL | R L | 04/01/87 | 1410V7 | 34 | | | 10000 | | 193.45 |
| 567563599 | HIBMA | R A | 04/01/87 | 2410V7 | 44 | | | 10000 | | 228.00 |

AGENT COPY

* BILLING QUESTIONS? CALL (800)323-5352

① Coverage Code: See explanation on reverse.
② Transaction Code: 1—Back Charge
2—Back Credit

| | |
|---|---|
| TOTAL MONTHLY COST | 421.45 |
| MONTHLY FEE | 15.00 |

| R.O. CODE | 51 | ACCOUNT NO. | PAYMENT DUE DATE Mo. Day Yr. | |
|---|---|---|---|---|
| LOC. CODE | 580 | | | |
| AGENT NO | 563867 | 64121789 | 03/01/88 | 8436.45 |

EXHIBIT 1

EXHIBIT 2

ALLSTATE

Group Life and Health Department
60 Allstate Plaza
Northbrook, Illinois 60062

March 31, 1987

Bob Lee
c/o Allstate
404 S. Montezuma
Prescott, AZ 86303

RE: Prescott Glass Corp.
Account No.: 64121789

Dear Bob:

Congratulations! Prescott Glass Corp. has been accepted for Allstate Group Insurance with an effective date of 12:01 a.m., April 1, 1987.

We appreciate your time and effort in making the sale and stand ready to serve you and your customer at any time. Should you need further information, please feel free to call us.

| | | |
|---|---|---|
| Services: | NEW YORK STATE ONLY | 516-752-5307 |
| | ALL OTHER STATES Toll Free | 800-323-5352 |
| | (Within Illinois) | 312-291-6821 |
| Underwriting: | Toll Free | 800-323-5353 |
| | IL Toll Free | 800-942-5387 |
| | (Agent's use only) | |
| Claims: | NEW YORK STATE ONLY | 516-752-5250 |
| | ALL OTHER STATES | 1-800-235-1847 |
| | (Within Illinois) | 312-364-2800 |
| | L & D | 312-291-5880 |

Enclosed are insurance certificates and administrative forms for your client. These materials are designed to assist them in the administration of the group program. We urge you to take a few minutes to review the materials before presenting them to the customer.

Sincerely,

/s/ Sue Daly
SUE DALY
AGI Underwriter

Ul/dlm

IN THE SUPERIOR COURT
OF THE STATE OF ARIZONA
IN AND FOR THE COUNTY OF MARICOPA

---

No. CV 90-11325

MICHAEL HIBMA, a single man, *et al.*,
*Plaintiff,*

vs.

ALLSTATE INSURANCE COMPANY,
an Illinois corporation, *et al.*,
*Defendants.*

---

DEPOSITION OF ROBERT HIBMA

VOLUME II

Phoenix, Arizona
June 25, 1993

* * * *

[52] Q. And I think at that time you said that it was delivered by Mr. Lee?

A. Yes.

Q. And at that time did you and Mr. Lee have any discussions about the policy or coverage or anything along those lines?

A. No, none other than, here's the policy we discussed previously and it's in effect, and here's your packet. You know, myself and Mr. Hull was on the group, could review or put it in our file and have it, you know.

Q. And from that date, the date of delivery of the packet—

A. Uh-huh.

Q. —through the date in which Michael was injured, did you ever have any questions of Mr. Lee concerning anything in the policy that you remember?

A. Not to my knowledge.

Q. The policy was issued in 1987. I think it became effective in April 1987. Before it issued, do you recall approximately how much time had elapsed between application and issuance? A month? Weeks?

A. Application of the insurance and the issuance? I wouldn't have thought it would have been more [53] than a month. You know, there may have been a prior insurance company that we were waiting for it to expire, you know, the premium, so, therefore, not to have a lapse. Could have been, but I wouldn't think if we had been seeking a new insurance, we would probably do it prior to 30 days before expiration of another policy, so I wouldn't have thought it more than a 30-day deal.

(Mrs. Sharon Hibma entered the room.)

Q. BY MR. GAONA: And as I understand it, you were the person who contacted Mr. Lee to get a quote for this particular plan?

A. It was mutual. He is an insurance salesman in Prescott that I have daily dealings with besides this insurance, you know, with regards to our Prescott Glass business.

Q. At one time you essentialy asked him for another quote, though, for a group policy?

A. Correct, exactly.

Q. And did you provide him with any parameters of the kind of coverage you were looking for at that time? Any specifics?

A. I just wanted major medical is all I was interested in. Not the daily office call visit-type stuff. I wanted to make sure we had a good major medical insurance plan for myself and my employees.

* * * *

[60] Q. Was that in a printout form? Do you remember? Computer printout form, or was it on a form document?

A. I don't remember. I am sure we would have had knowledge of how much the premium was going to be prior to initiating the policy, but I don't recall if it was a printed document or if it was—I am sure it must have been something. He must have gotten a quote from the company and shared with me, here's what they quote, "X" amount of dollars. I really don't recall.

Q. This was something you remember discussing with Mr. Lee upon receiving the quote?

A. Yes, uh-huh.

Q. How about Mr. Hull? Did you share that with Mr. Hull? Do you remember?

A. I may or may not have. Again, it was the responsibility of the company to pay for it and not Mr. Hull. It was a benefit to him, so whether I shared that with him, I don't know.

Q. Was anyone else anticipated for coverage at that time other than you and Mr. Hull and your family?

A. No.

* * * *

IN THE SUPERIOR COURT
OF THE STATE OF ARIZONA
IN AND FOR THE COUNTY OF MARICOPA

---

No. CV-90-11325

MICHAEL HIBMA, a single man, *et al.*,
*Plaintiffs,*

vs.

ALLSTATE INSURANCE COMPANY,
an Illinois corporation, *et al.*,
*Defendants.*

---

DEPOSITION OF ROBERT ALAN LEE

Prescott, Arizona
June 25, 1990

* * * *

[22] Q. Did you speak—when you called up to give the quotation back did you speak with Bob Hibma or Sharon Hibma?

A. Bob.

Q. Then an appointment was set up to meet.

Did that follow through?

A. Yes, we made out the application in his office.

Q. Okay.

And were there any other meetings that you had with either Bob or Sharon Hibma when the policy was set up?

A. No.

I did meet with them to deliver the package, after it was accepted, and that I gave to Bob.

Q. Okay.

Was Sharon present at that time?

A. No.

Q. That delivery, then, of the package, would have been after this March 31st, 1987 date?

A. Yes, I would assume so.

Q. What was in the package of documents that you gave to Bob Hibma?

A. Basically a booklet for the policy itself, what it entailed, what was in there, what it covered. Claim forms, a letter, you know, accepting their policy, and claim [23] envelopes.

Q. Anything else?

A. That's all I would think was in there.

Q. And you say, "that's all I would think."

What you've told me is basically what you normally would give to an insured on delivery of a policy?

A. Right.

Q. Do you have a specific recollection of what it was that you gave him on this date?

A. I gave him the full packet.

Q. And you've just described the full packet for me, the contents of it?

A. I believe so.

* * * *

[Dated June 15, 1992]

IN THE SUPERIOR COURT
OF THE STATE OF ARIZONA
IN AND FOR THE COUNTY OF MARICOPA

---

No. CV-90-11325

MICHAEL HIBMA, a single man, *et al.*,
*Plaintiffs,*

vs.

ALLSTATE INSURANCE COMPANY,
an Illinois corporation, *et al.*,
*Defendants.*

---

ALLSTATE LIFE'S STATEMENT
OF FACTS IN SUPPORT OF ITS
MOTION FOR SUMMARY JUDGMENT

(Assigned to the Honorable Thomas Dunevant, III)

Pursuant to Rule IV(f), *Uniform Rules of Practice of the Superior Court of the State of Arizona*, Allstate Life respectfully submits its statement of facts in support of its motion for summary judgment as follows:

1. Effective April 1, 1987, Prescott Glass Corporation became a participating employer insured by the Allstate Life Insurance Company under a group contract issued to the trustee of the First Insurance Trust. (Letter dated December 21, 1989, attached hereto as Exhibit 1; letter dated March 31, 1987, attached hereto as Exhibit 2; Declaration Page, attached hereto as Exhibit 3).

2. Robert Hibma became insured under the Prescott Glass Corporation policy as he was an employee. Mr. Hibma insured himself and his eligible dependents. (Letter dated December 21, 1989, attached hereto as Exhibit 1).

3. On or about February 15, 1989, Michael Hibma, Robert Hibma's dependent son, sustained serious injury as he was operating an all-terrain vehicle on a sand dune in Imperial County, California. (Compliant, Cause No. CV89-04365, "Robert Hibma and Sharon Hibma, husband and wife; Michael Hibma, single man, plaintiffs v. John Does I-X; U.S. Suzuki Motor Corporation, a California corporation; Suzuki Motor Corporation, Ltd., a Japanese corporation; Robert Riggle and Jane Doe Riggle, husband and wife, and d/b/a Thunder Ridge Kawasaki and Suzuki, defendants", paragraph 3).

4. On February 17, 1989, Allstate Life Insurance Company terminated all group insurance policies under the AGI plan, and provided Prescott Glass Corporation notice of the termination in a letter. The letter further informed Prescott Glass Corporation and its certificate holders that coverage would terminate on May 1, 1989 at 12:01 a.m. (Letter, dated February 17, 1989, attached hereto and incorporated by this reference and marked as Exhibit 4).

5. Upon the termination of the AGI group plan, plaintiff Michael Hibma was eligible for an extension of benefits and/or the conversion privilege offered pursuant to the group plan. Michael Hibma qualified for the 12 month extension of benefits provision as he was totally disabled upon the Prescott Glass group insurance plan terminating, April 1, 1989. (See letter dated December 21, 1989, attached hereto as Exhibit 1).

6. The group insurance certificate that sets forth the contract between the plaintiff and Allstate Life provided that Allstate Life could "end or amend the group policy on any premium due date after the first policy anniversary. To do this, we [Allstate Life] must give at least 60 days written notice to the policyholder." (Group Insurance Certificate Amendment, Plan LGU8900, attached hereto as Exhibit 5).

7. The Allstate group insurance plan provided to the plaintiff provided the manner in which medical benefits would be paid as follows:

> The medical benefit is paid for eligible expense incurred for an injury or sickness while insured.

(AGI certificate, p. 12, attached hereto as Exhibit 5).

8. At the time the Allstate Life group insurance plan was purchased by Prescott Glass, Robert Lee, the Allstate Life agent who sold the policy, dealt solely with Robert Hibma concerning the sale of the plan to Prescott Glass Corporation. (See deposition of Robert Lee, June 25, 1990, pp. 20, 22, attached hereto and marked as Exhibit 6).

DATED this 15th day of June, 1992.

DeConcini McDonald Brammer
Yetwin & Lacy, P.C.

By /s/ David F. Gaona
David F. Gaona
2901 North Central Avenue
Suite 1644
Phoenix, Arizona 85012-2736

Attorneys for Defendants

EXHIBIT 1

ALLSTATE

Allstate Plaza West
3100 Sanders Road
Northbrook IL 60062
312-402-5000

December 21, 1989

Mr. Tom Boston
Assistant Coordinator
State of Arizona
Department of Insurance
Abacus Towers
3030 N. 3rd Street, Suite 1100
Phoenix, AZ 85012

RE: Mrs. Sharon Hibma
Account Name: Prescott Glass Corporation
Account Number: 64121789

Dear Mr. Boston:

Your letter of December 7, 1989 to Ms. Marge Coari has been forwarded to me for response. All questions regarding group insurance are handled at Allstate Life Insurance Company's home office, at the address shown above.

In reviewing our file, I have determined the following:

- Effective April 1, 1987, Prescott Glass Corporation became a participating employer insured by the Allstate Life Insurance Company under a group contract issued to the Trustee of the First Insurance Trust.
- The coverage selected by Prescott Glass for its employees and eligible dependents was group life and group comprehensive medical coverage.

- Robert Hibma became insured as employee under Prescott Glass Corporation's group insurance plan on its original Allstate effective date (April 1, 1987). Mr. Hibma insured himself and his eligible dependents.
- Prescott Glass was notified on February 21, 1989, via certified mail, that coverage would terminate unless terminated earlier by the employer. A copy of the letter sent to Prescott Glass and a copy of the certified receipt are attached. Also attached is the employee notice which was included with the letter sent to each employer.
- Prescott Glass did not pay premium for the month of April, 1989. Coverage for Prescott Glass terminoted with Allstate Life Insurance Company effective April 1, 1989.
- This termination is in accordance with the certificates issued to Prescott Glass.
- The master policy issued to the Trustee contains all benefits available to all employers. Certificates are issued to each employer which describe the benefits the employer has selected. A copy of the certificate issued to Prescott Glass is enclosed for your reference.

When insurance terminates, insureds may be eligible for an extension of benefits and/or the Conversion Privilege. In order for these provisions to apply, all respective requirements must be satisfied as outlined in the certificate. Coverage provided under conversion meets state-mandated levels; however, in most instances, benefits are substantially less than those available under the group insurance plan.

Both Mr. and Mrs. Hibma contacted Allstate Life regarding the extension of benefits for their son Michael. Our Claims Department has advised them that Michael Hibma qualified for a 12 month extension of benefits

when the Prescott Glass group insurance plan terminated. This extension will end on April 1, 1990.

Allstate Life Insurance Company sent conversion information to the Hibmas on March 31, 1989. Our conversion unit indicates that Mr. Hibma did not exercise his conversion privilege.

The group medical insurance plan purchased by Prescott Glass from Allstate Life Insurance Company provides standard comprehensive medical expense coverage. Benefits are payable only on an expense incurred basis. This has been explained to Mrs. Hibma by our Claims Department.

Under the Prescott Glass plan, the maximum benefit per insured person per lifetime was $1,000,000. This means that Allstate Life Insurance Company would have paid up to $1,000,000 for all eligible expenses incurred by an insured person during the period the group insurance plan remained in force, and during any applicable extension of benefits period. No benefits are available beyond the end of the extension of benefits.

Allstate Life Insurance Company's decision to withdraw from the group insurance market was a difficult one. In this termination process, we must treat all employers the same. We are, therefore, unable to accept Mrs. Hibma's proposal that coverage be continued beyond the plan termination date.

The coverage provided to the Hibmas under the Prescott Glass group plan terminated in accordance with the provisions entitled, "Termination of the Group Policy or the Employer's Plan." I regret Mrs. Hibma's obvious distress; however, Allstate Life Insurance Company must administer all coverage in accordance with the certificate.

In response to Mrs. Hibma's statements regarding the rates on Prescott Glass's group insurance plan, Prescott Glass received an annual rate review and increase effec-

tive April 1, 1989. I have attached copies of the Hibmas' letters and Allstate Life's response dated March 31, 1989.

Please feel free to contact me at (708) 402-2627 if you have any questions or require additional information.

Sincerely,

/s/ Janice A. Kidd
JANICE A. KIDD

cmc
Attachments

EXHIBIT 2

ALLSTATE ®

Group Life and Health Department
60 Allstate Plaza
Northbrook, Illinois 60062

March 31, 1987

Bob Lee
c/o Allstate
404 S. Montezuma
Prescott, AZ 86303

RE: Prescott Glass Corp.
Account No.: 64121789

Dear Bob:

Congratulations! Prescott Glass Corp. has been accepted for Allstate Group Insurance with an effective date of 12:01 a.m., April 1, 1987.

We appreciate your time and effort in making the sale and stand ready to serve you and your customer at any time. Should you need further information, please feel free to call us.

| | | |
|---|---|---|
| **Services:** | NEW YORK STATE ONLY | 516-752-5307 |
| | ALL OTHER STATES Toll Free | 800-323-5352 |
| | (Within Illinois) | 312-291-6821 |
| **Underwriting:** | Toll Free | 800-323-5353 |
| | IL Toll Free | 800-942-5387 |
| | (Agent's use only) | |
| **Claims:** | NEW YORK STATE ONLY | 516-752-5250 |
| | ALL OTHER STATES | 1-800-235-1847 |
| | (Within Illinois) | 312-364-2800 |
| | L & D | 312-291-5880 |

Enclosed are insurance certificates and administrative forms for your client. These materials are designed to assist them in the administration of the group program. We urge you to take a few minutes to review the materials before presenting them to the customer.

Sincerely,

/s/ Sue Daly
SUE DALY
AGI Underwriter

U1/dlm

# ALLSTATE GROUP INSURANCE
## CERTIFICATE OF COVERAGE

ACCOUNT NUMBER: 64121789

EMPLOYER: PRESCOTT GLASS CORP.

ADDRESS: PRESCOTT AZ 86301

EMPLOYEE: R HIGMA

CERTIFICATE NUMBER: 567563599

EFFECTIVE DATE: 04/01/87

CLASS: 4

SCHEDULE OF BENEFITS

AMOUNT OF LIFE INSURANCE BENEFIT $10000
AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT PRINCIPAL SUM: $10000
AMOUNT OF DEPENDENT LIFE INSURANCE BENEFIT: SPOUSE AND CHILD(REN) 6 MOS.-
AGE LIMIT-$1,000.00
CHILD(REN) 14 DAYS-6 MOS.-$100.00

MEDICAL EXPENSE INSURANCE PLAN: V
CASH DEDUCTIBLE: $300.00
CO-INSURANCE FACTOR: FOR ALL ELIGIBLE EXPENSE OTHER THAN FOR
OUT-PATIENT PSYCHIATRIC TREATMENT - 80%
FOR OUT-PATIENT PSYCHIATRIC TREATMENT - 50%
CO-INSURANCE LIMIT: FOR ALL ELIGIBLE EXPENSE OTHER THAN FOR
PSYCHIATRIC TREATMENT - $5,000.00
OUT-PATIENT PSYCHIATRIC TREATMENT MAXIMUM: $1,000.00 PER BENEFIT PERIOD
SUPPLEMENTAL ACCIDENT BENEFIT MAXIMUM: $300.00 PER ACCIDENT
MEDICAL MAXIMUM: UNLIMITED
DEPENDENT MEDICAL EXPENSE INSURANCE COVERAGE IS INCLUDED.

THE CERTIFICATE OF COVERAGE, CERTIFICATE BOOKLET, AND ANY CERTIFICATE AMENDMENT CONSTITUTE YOUR CERTIFICATE OF INSURANCE. REFER TO YOUR CERTIFICATE BOOKLET AND CERTIFICATE AMENDMENTS FOR DEFINITIONS, LIMITATIONS AND EXCLUSIONS.

AG:::

This card is issued for the convenience of the employee and the hospital. It is not a guarantee of coverage.
TO ALL HOSPITALS
To confirm eligibility please contact

PRESCOTT GLASS CORP.

203 E. SHELDON ST
PRESCOTT AZ 86301
Employee R HIGMA
Certificate Number 56756359
Account Number 64121789
Employee's Effective Date 04/01/87

LGU:19?:

This card is issued for the convenience of the employee and the hospital. It is not a guarantee of coverage.
TO ALL HOSPITALS
To confirm eligibility please contact

PRESCOTT GLASS CORP.

203 E. SHELDON ST
PRESCOTT AZ 86301
Employee R HIGMA
Certificate Number 56756359
Account Number 64121789
Employee's Effective Date 04/01/87

EXHIBIT 4

ALLSTATE ®

Allstate Life Insurance Company
Group Life & Health Department
60 Allstate Plaza
Northbrook, IL 60062

February 17, 1989

Prescott Glass Corp.
208 E. Sheldon St.
Prescott, AZ 86301

RE: Account #64121789
Termination of Group Insurance Policies

The group insurance industry has experienced rapid changes over the last few years, principal among those changes being the development of managed health care programs. We do not currently have a managed care program to offer to our group insurance customers, nor does our volume of business warrant the extensive investment that would be required in order for us to develop an effective program. We have, therefore, regretfully decided to withdraw from the group insurance market. In order to effect this withdrawal, we are terminating existing policies.

The group insurance program purchased by your company was secured through participation in The First Insurance Trust. This Trust provided insurance protection through policies issued by Allstate Life Insurance Company. The policies provide for termination by the insurer upon at least 60 days notice to the Trustee.

In accordance with our agreement with the Trustee of The First Insurance Trust, Allstate Life Insurance Company has exercised its right to terminate these insurance policies. This includes any policies covering your employee group. Unless terminated earlier at your request, for non-payment of premim, or for any other contractual

reason, your coverage will terminate on May 1, 1989, at 12:01 a.m.

Enclosed is a notice that should be distributed to each employee covered by the Allstate plan. Any former employees continuing coverage under the Allstate plan should also receive a notice.

The certificates of insurance and any amendments that have been issued describe in detail the rights of insured employees and dependents, including those relating to conversion or extension of benefits.

We suggest that you contact other sources as soon as possible to obtain coverage with another insurance carrier.

Sincerely,

/s/ Robert L. Glodowski
ROBERT L. GLODOWSKI
Group Marketing Manager

Enclosure

cc: Agent 643867 51 580

SENDER: Complete items 1 and 2 when additional services are desired, and complete items 3 and 4.

Put your address in the "RETURN TO" Space on the reverse side. Failure to do this will prevent this card from being returned to you. The return receipt fee will provide you the name of the person delivered to and the date of delivery. For additional fees the following services are available. Consult postmaster for fees and check box(es) for additional service(s) requested.

1. ☐ Show to whom delivered, date, and addressee's address. (Extra charge)
2. ☐ Restricted Delivery (Extra charge)

3. Article Addressed to:

64121789
PRESCOTT GLASS CORP.
208 E. SHELDON ST
PRESCOTT, AZ 86301

4. Article Number: P 655 355 470

Type of Service:
- ☐ Registered
- ☐ Certified
- ☐ Express Mail
- ☐ Insured
- ☐ COD
- ☐ Return Receipt for Merchandise

Always obtain signature of addressee or agent and DATE DELIVERED.

5. Signature – Addressee
X [signature]

6. Signature – Agent
X

7. Date of Delivery: 2/21/89

8. Addressee's Address (ONLY if requested and fee paid)
SAME AS IN SP. "3"

PS Form 3811, Mar. 1988 • U.S.G.P.O. 1988-212-865 DOMESTIC RETURN RECEIPT

## EXHIBIT 5

ALLSTATE LIFE INSURANCE COMPANY
NORTHBROOK, ILLINOIS

(Herein called We/Us/Our/Allstate)

GROUP INSURANCE CERTIFICATE AMENDMENT

Notice is hereby given that the Certificate of Insurance summarizing the insurance provided through your Employer is amended as follows:

The Dependent Life Insurance Provisions shown below are hereby added to the Certificate.

DEPENDENT LIFE INSURANCE PROVISIONS

INSURING PROVISIONS

Eligibility

As an insured Employee, you may enroll your eligible dependents for Dependants' Insurance. The following persons are eligible:

- your lawful spouse; and
- your unmarried children who:
  - —depend upon you for over one-half of their financial support; and
  - —are 14 days old but less than 19 years old, or less than 23 years old if a full-time student in a secondary school, college or university.

The term "children" includes step children, legally adopted children and foster children.

No person is eligible for insurance both as an Employee and as a dependent. If both parents of a child are insured Employees under the Employer's Plan, the child may be insured as the dependent of only one parent.

Effective Date of Non-Contributory Insurance

You are not required to pay for any Non-Contributory Insurance for your eligible dependents. In this case, insurance begins on the first of the month coinciding with or next following the date your dependents become eligible.

Effective Date of Contributory Insurance

You are required to pay for any Contributory Insurance for your eligible dependents. In this case, insurance begins on the effective date shown below:

- When a Contribution Agreement is signed on or before the date a person becomes eligible: The effective date is the first of the month coinciding with or next following the date the person becomes eligible.
- When a Contribution Agreement is signed within 31 days after the date a person becomes eligible: The effective date is the first of the month coinciding with or next following the date of the signing.
- When a Contribution Agreement is signed more than 31 days after the date a person becomes eligible: The effective date is determined by Us, based on Our standard processing rules. The person must provide, at their own expense, proof of good health that is acceptable to Us.

Termination of Insurance

Subject to the Continuance of Insurance provision, a dependent's insurance ends when the first of these events takes place:

- the date your insurance ends;
- the date the group policy or the Employer's Plan is changed to end Dependents' Insurance;

- the month the dependent is no longer eligible for this insurance, in which case insurance stops at the end of that month; or
- for Contributory Insurance, the end of the period for which you have paid for the insurance.

The end of insurance will not affect any claim made for a loss that took place while the insurance was in force.

## BENEFIT PROVISIONS

Death Benefit

We will pay the Amount of Life Insurance Benefit for dependents shown in the Schedule of Benefits if:

- your dependent dies while insured under the Employer's Plan; and
- We receive due proof of claim.

Payment will be made in accord with the Payment of Benefits—Beneficiary provision in the General Provisions.

Continuance of Insurance

A dependent's Life Insurance may continue after it would otherwise have ended under the Termination of Insurance provision. This applies as follows:

Thirty-One Day Benefit. This benefit provides 31 days of coverage that begin when your dependent is first eligible to use the Conversion Privilege. If your dependent dies during these 31 days, we will pay a death benefit under the Employer's Plan. The amount We will pay is the maximum amount of life insurance that your dependent was allowed to convert under the Employer's Plan. It does not matter whether your dependent applied for the conversion coverage.

## Conversion Privilege

### When Insurance Ends

A dependent whose insurance, or any portion of it, ends because the dependent is no longer in an eligible class may convert this group life insurance to an individual policy. This also applies if the Employee dies, or changes to a class that is not eligible, or is no longer employed. The Employer must give the dependent written notice of this right to convert. The notice may be given in person or mailed to the dependents' home address as shown in the Employer's records.

The dependent need not furnish proof of good health. However, the conversion is subject to all of these terms:

- the dependent must apply in writing and pay the first premium no later than;

  —31 days after the dependent's group life insurance ends; or

  —15 days after the dependent is given notice of the conversion privilege—but no later than 91 days after group life insurance ends.

- the individual policy must be of a type We commonly issue, but not one containing term or disability insurance or other added benefits;

- the individual policy will take effect at the end of the 31 day period after the dependent's group life insurance ends;

- the premium is based on Our rate for the dependent's class of risk and age at that time; and

- the amount of life insurance may not be more than the insurance that ceased under the Employer's Plan—less the amount of group life insurance for which the dependent becomes eligible during the 31 days after the dependent's group life insurance ends.

When the Group Policy or the Employer's Plan Ends or Changes

A dependent who has been insured by the Employer's Plan for at least five years may convert this group life insurance to an individual policy if;

- the life insurance ends because the group policy or the Employer's Plan ends; or
- the Employer's Plan is changed to end life insurance for the class to which the dependent belongs.

The conversion is subject to the same terms as in the section above, except that the amount of life insurance may not be more than the lesser of:

- $10,000; or
- the amount of group life insurance the dependent had on the date the Employer's Plan ended or changed—less the amount of group life insurance for which the dependent becomes eligible during the 31 days after the date the Employer's Plan ends or changes.

Effect of the Group Policy on Conversion Coverage

A specific rule applies if a dependent converts to an individual policy and then dies while Life Insurance is continued under the Continuance of Insurance provision. We will only pay the benefits under the Employer's Plan if the individual policy is surrendered to Us with no claim—other than a return of premium, less any debt.

## GENERAL PROVISIONS

Definitions

"Dependents' Insurance" means insurance the Employer's Plan provides for an insured Employee's eligible dependents.

For other Definitions, please refer to your Certificate of Insurance.

Payment of Benefits—Beneficiary

All benefits for loss of a dependent's life will be paid to you. If you die first, payment will be made to your beneficiary on file at Our office.

This amendment is effective on the Effective Date shown in your Certificate, or if later, on the Effective Date shown below. Except as amended, the Certificate remains unchanged.

Effective Date:

/s/ Herbert E. Lister
President

ALLSTATE LIFE INSURANCE COMPANY
NORTHBROOK, ILLINOIS

(Herein called We/Us/Our/Allstate)

GROUP INSURANCE CERTIFICATE AMENDMENT

Notice is hereby given that the Certificate of Insurance summarizing the insurance provided through your Employer is amended as follows:

I. The Accident Expense Insurance Provisions shown below are hereby added to the Certificate.

ACCIDENT EXPENSE INSURANCE PROVISIONS

SCHEDULE OF BENEFITS

Accident Maximum ..... $300 per injury

ACCIDENT BENEFIT

If an insured person has an injury and incurs Expense within 90 days of the injury, We will pay the lesser of:

- the actual Eligible Expense incurred, or
- the Acident Maximum shown in the Schedule of Benefits.

ELIGIBLE EXPENSE

"Eligible Expense" means the following Expense incurred for an injury sustained while insured:

1. Room and Board for each day of a Hospital stay.
2. charges made by a Hospital for Miscellaneous Services.
3. services of a Physician.
4. services of a radiologist, anesthesiologist, or pathologist.
5. emergency transportation that is:

- within or between the United States, Canada, and Puerto Rico;
- by a licensed ambulance service, regularly scheduled airline, an ambulance, or railroad; and
- from the place of injury to the nearest Hospital able to provide needed treatment.

6. anesthesia, oxygen, or other gases and the rental of equipment to administer them.
7. the services of a licensed physical therapist, registered nurse, or Christian Science nurse listed in the current issue of the Christian Science Journal, except for one who:
   - lives in the insured person's home, or
   - is the insured person's spouse, child, or parent.
8. X-ray or laboratory exams.
9. drugs or medicines obtainable only upon written prescription by a Physician.
10. casts, splints, surgical dressings, or trusses.
11. the rental cost—up to the purchase price—of crutches, wheelchairs, hospital beds, or iron lungs.
12. prosthetic or orthopedic devices, such as artificial limbs, eyes, or braces for a loss or injury which occurs while the person is insured.
13. blood transfusions—including the cost of whole blood or plasma not donated or replaced.

LIMITATIONS

No benefit wil be paid for Expense incurred for or in connection with:

1. intentionally self-inflicted injury while sane or insane.
2. war or act of war, rebellion, or taking voluntary part in a Riot.

3. military service for any country or organization, including service with military forces as a civilian whose duties do not include combat.

4. taking part in a felony.

5. injury for which the insured person is not under the Regular Care of a Physician.

6. injury covered under any Workers' Compensation or Occupational Disease Law.

7. services or supplies from a government owned or operated Hospital—unless a charge must be paid by the insured person.

8. services of a Physician employed by any government —unless a charge must be paid by the insured person.

9. charges to the extent that they are in excess of the Reasonable and Customary Charges for services and supplies.

10. charges for unnecessary care or treatment or care not uniformly or professionally endorsed as standard medical care.

CONTINUANCE OF INSURANCE

If your Medical Expense Insurance is continued, your Accident Expense Insurance may also be continued. However, this continuance is subject to the same terms as shown in the Continuance of Insurance Comprehension for Comprehensive Medical Insurance. Please refer to your Certificate of Insurance for furtherance.

II. The provision entitled "Medical Deductible" under the Comprehensive Medical Insurance is changed to read as follows:

MEDICAL DEDUCTIBLE

The Medical Deductible applies to each insured person for each Benefit Period. The Medical Deductible is equal to the sum of:

- The Cash Deductible shown in the Schedule of Benefits;
- The benefits payable under the Accident Benefit; and
- The benefits payable under any other plan the Employer sponsors or contributes to—provided the Expense is an Eligible Expense under these provisions.

This amendment is effective on the Effective Date shown in your Certificate, or if later, on the Effective Date shown below. Except as amended, the Certificate remains unchanged.

Effective Date:

/s/ Herbert E. Lister
President

ALLSTATE LIFE INSURANCE COMPANY

NORTHBROOK, ILLINOIS

(Herein called We/Us/Our/Allstate)

This booklet explains the essential features of the group insurance plan being made available through your Employer. Allstate hereby certifies that when a Certificate of Coverage is issued the named Employee becomes insured for the benefits indicated therein. The Certificate of Coverage and this booklet form your Certificate of Insurance.

All benefits are subject to the terms and conditions of the Group Policies. Allstate hereby certifies that the Group Policies have been issued to and are in the possession of the Trustee of the First Insurance Trust, herein called the Policyholder.

Your Certificate of Insurance replaces prior certificates, if any, that provide similar benefits. It is not and will not become the contract of insurance.

/s/ Herbert E. Lister
President

# ALLSTATE GROUP INSURANCE

## BENEFITS

## TABLE OF CONTENTS


INSURING PROVISIONS — Page

Eligibility for Insurance
Effective Date of Non-Contributory Insurance
Effective Date of Contributory Insurance
Contribution Amounts
Termination of Insurance
Termination of the Group Policy or the Employer's Plan

EMPLOYEE LIFE INSURANCE

Death Benefit
Optional Methods of Settlement
Continuance of Insurance
Total Disability Benefit
Conversion Privilege

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT

Accidental Death and Dismemberment Benefit
Continuance of Insurance
Limitations

COMPREHENSIVE MEDICAL INSURANCE

Benefit Period
Medical Deductible
Cash Deductible Provisions
Medical Benefit
Maximum Benefit
Eligible Expense
Continuance of Insurance
Extension of Benefit
Limitations
Effect of Medicare
Coordination of Benefits
Conversion Privilege

TABLE OF CONTENTS—Continued

GENERAL PROVISIONS

Page

Definitions
Entire Contract
Policy Changes
Conformity with the Law
Employee Certificates
Misstatements or Clerical Error
Incontestability
No Effect on Workers' Compensation
Information to be Furnished
Assignment
Notice of Claim
Proof of Claim
Payment of Benefits-Beneficiary
Facility of Payment
Legal Actions
Physical Exams and Autopsy

FINANCIAL PROVISIONS

Premium Due Date
Grace Period
Premium Calculation
Change of Employer's Plan and Premium Rates

## INSURING PROVISIONS

### ELIGIBILITY FOR INSURANCE

Employees

You are eligible for Employees' Insurance if you:

- are in an Eligible Class; and
- have completed the Service Requirement, if any.

The Eligible Class or Classes of Employees and Service Requirements are shown in the Employer's Application.

Dependents—Medical Expense Insurance

As an insured Employee, you may enroll your eligible dependents for Dependents' Insurance. The following persons are eligible:

- your lawful spouse; and
- your unmarried children who:
  - —depend on you for over one-half of their financial support; and
  - —are less than 19 years old, or less than 23 years old if a full-time student in a secondary school, college, or university.

The term 'children' includes step children, legally adopted children, and foster children.

No person is eligible for insurance both as an Employee and as a dependent. If both parents of a child are insured Employees under the Employer's Plan, the child may be insured as the dependent of only one parent.

### EFFECTIVE DATE OF NON-CONTRIBUTORY INSURANCE

Employees

You are not required to pay for any Non-Contributory insurance. In this case, insurance begins on the first of the

month coinciding with or next following the date you become eligible. However, you cannot become insured if you are absent from work due to injury or Sickness. In this case, you will become insured on the first of the month coinciding with or next following the date of return to Active Work.

Dependents—Medical Expense Insurance

You are not required to pay for Non-Contributory Insurance for your eligible dependents. In this case, insurance begins on the first of the month coinciding with or next following the date your dependent becomes eligible. However, there are these exceptions:

- Your dependents, other than a newborn child, cannot become insured if they are Totally Disabled. In this case, the dependents will become insured on the first of the month coinciding with or next following the date they are no longer Totally Disabled.
- An eligible newborn child becomes insured at birth.

## EFFECTIVE DATE OF CONTRIBUTORY INSURANCE

Employees

You are required to pay for any Contributory Insurance. In this case, insurance begins on the effective date shown below:

- When a Contribution Agreement is signed on or before the date a person becomes eligible: The effective date is the first of the month coinciding with or next following the date that person becomes eligible.
- When a Contribution Agreement is signed within 31 days after the date a person becomes eligible:

The effective date is the first of the month coinciding with or next following the date of the signing.

- When a Contribution Agreement is signed more than 31 days after the date a person becomes eligible: The effective date is determined by Us, based on Our standard processing rules. The person must provide, at their own expense, proof of good health that is acceptable to Us.

However, you cannot become insured if you are absent from work due to Injury or Sickness. In this case, you will become insured on the first of the month coinciding with or next following the date of return to Active Work.

Dependents—Medical Expense Insurance

You are required to pay for any Contributory Insurance for your eligible dependents. When insurance begins depends upon when a Contribution Agreement is signed as explained above. However, there are these exceptions:

- Your dependents, other than a newborn child, cannot become insured if they are Totally Disabled. In this case, the dependents will become insured on the first of the month coinciding with or next following the date they are no longer Totally Disabled.
- An eligible newborn child is insured for the first 31 days after birth even if a Contribution Agreement has not been signed. But, one must be signed for insurance to continue past these 31 days. Any added premium must be paid from the date of birth.

CONTRIBUTION AMOUNTS

The Employer must determine the amount of contribution required from each Employee. This must be done in a way that does not single out any Employee for a special rate.

## TERMINATION OF INSURANCE

### Employees' Insurance

Subject to the Continuance of Insurance provisions as listed in the Table of Contents, your insurance ends when the first of these events takes place:

- the date the group policy or the Employer's Plan ends;
- the date the group policy or the Employer's Plan is changed to end insurance for the class to which you belong;
- the month you are no longer in an eligible class, in which case insurance stops at the end of that month;
- for Contributory Insurance, the end of the period for which you have paid for the insurance; or
- for all insurance, other than Life Insurance, the month you reach age 75, in which case insurance stops at the end of that month.

The end of insurance will not affect any claim made for a loss that took place while the insurance was in force.

### Dependents' Insurance—Medical Expense Insurance

Subject to the Continuance of Insurance provision, a dependent's insurance ends when the first of these events takes place:

- the date your insurance ends;
- the date the group policy or the Employer's Plan is changed to end Dependents' Insurance;
- the month the dependent is no longer eligible for this insurance, in which case insurance stops at the end of that month;
- for Contributory Insurance, the end of the period for which you have paid for the insurance; or

- the month the dependent reaches age 75, in which case insurance stops at the end of that month.

Age limits may be waived for a mentally retarded or physically handicapped child. The child may remain insured beyond the age insurance would end, if the child:

- is not capable of working at a self-sustaining job; and
- depends mainly on you for support and care.

We may request proof that the child is eligible for continued insurance. If We do not request proof within two months of the child reaching the limiting age, the child's insurance continues. If We do not receive proof within 31 days of Our request, the child's insurance ends at the later of:

- attainment of the limiting age; or
- the end of the 31 day period.

The continued insurance is subject to all of the terms of the Employer's Plan.

If you die, Dependents' Insurance continues for 90 days after your death, subject to all of the provisions of the Employer's Plan.

The end of insurance will not affect any claim made for a loss that took place while the insurance was in force.

## TERMINATION OF THE GROUP POLICY OR THE EMPLOYER'S PLAN

The Employer may end the Employer's Plan on any premium due date by giving written notice to Us at least 31 days in advance.

The Employer's Plan also ends at the end of the Grace Period if the premium is unpaid. This is in accord with the Grace Period provision of the Financial Provisions.

We may also end the Employer's Plan on any premium due date if:

- less than two Employees are insured;
- any Employees' Insurance is Contributory and less than 75% of those eligible are insured; or
- all Employees' insurance is Non-Contributory and less than 100% of those eligible are insured.

If We end the Employer's Plan, We must give written notice at least 31 days in advance.

We may end the group policy on any premium due date after the first policy anniversary. To do this, We must give at least 60 days written notice to the Policyholder.

## EMPLOYEE LIFE INSURANCE

### DEATH BENEFIT

We will pay the Amount of Life Insurance Benefit shown in the Schedule of Benefits if:

- you die while insured under the Employer's Plan; and
- We receive due proof of claim.

Payment will be made in accord with the Payment of Benefits—Beneficiary provision in the General Provisions.

### OPTIONAL METHODS OF SETTLEMENT

You may make a written request to Us that We pay the proceeds of your Life Insurance in installments. The amount and terms must be in accord with those We commonly offer at the time for group life insurance proceeds. If you do not elect an Optional Method of Settlement, your beneficiary may do so after your death.

### CONTINUANCE OF INSURANCE

Your Life Insurance may continue after it would otherwise have ended under the Termination of Insurance provision. This applies to the following three benefits:

#### Thirty-One Day Benefit

This benefit provides 31 days of coverage that begins when you are first eligible to use the Conversion Privilege. If you die during these first 31 days, We will pay a death benefit under the Employer's Plan. The amount We will pay is the maximum amount of life insurance that you were allowed to convert under the Employer's Plan. It does not matter whether you applied for the conversion coverage.

#### Elective Benefit

This benefit may provide continued life insurance for you if you are on an approved leave of absence or temporary

layoff. If the Employer elects to pay the premium, your Life Insurance will continue until the first of these events takes place:

- the date the Employer stops paying the premium for your insurance;
- the date the leave of absence or layoff ends; or
- the date the leave or layoff has lasted three months.

The Employer must decide when to continue or stop paying the premium, within the limits explained above. The Employer must not single out any one Employee for special treatment.

Six-Month Benefit

This benefit may provide continued life insurance if you:

- become Totally Disabled; and
- are not otherwise entitled to continue life insurance under any other provision of the group policy.

To continue insurance, you must pay the required premium, if any, to the Employer. Your Life Insurance will then continue until the first of these events takes place.

- the date the Total Disability ends;
- the end of the period for which any required premium has been paid;
- the date the Total Disability has lasted six months; or
- the date the group policy or the Employer's Plan ends.

TOTAL DISABILITY BENEFIT

The Total Disability Benefit extends your Life Insurance with no further premium payment. This will happen if you become Totally Disabled:

- before age 60; and
- while insured under the Employer's Plan.

We will extend your Life Insurance during the first 12 months of Total Disability. If you die in these 12 months, We must receive proof that the Total Disability continued until the date of death.

For each 12-month period after the first year, you must give Us proof that the Total Disability has continued. We must receive this proof within three months before the start of each new 12-month period. We will then extend your Life Insurance for another 12 months.

If you die after the first 12 months, We must receive proof that the Total Disability continued from the start of that 12-month period until the date of death.

While you are disabled, We have the right to have you examined by a Physician at any time We reasonably require. This will not be more than once a year after the Life Insurance has been continued for two full years under this provision. Any exams We require will be at Our expense.

This extension of Life Insurance ends on the date when the first of these events takes place:

- the Total Disability ends;
- you fail to give Us required proof of Total Disability;
- you fail to submit to a required exam; or
- you reach 70 years of age.

When this Life Insurance ends and you do not return to Active Work, then you have the same Conversion Privilege that is given when employment ends.

The amount of your Life Insurance under this provision is the same as the amount when Total Disability begins.

However, any provisions for ending this Life Insurance are still in effect.

CONVERSION PRIVILEGE

When Employment Ends or Changes

If your insurance, or any portion of it, ends because you are no longer employed, you may convert this group life insurance to an individual policy. This also applies if you are still employed but change to a class that is not eligible. The Employer must give you written notice of this right to convert. The notice may be given to you in person or mailed to your home address as shown in the Employer's records.

You need not furnish proof of good health. However, the conversion is subject to all of these terms:

- you must apply in writing and pay the first premium no later than:
  - —31 days after your group life insurance ends; or
  - —15 days after you are given notice of this conversion privilege—but no later than 91 days after your group life insurance ends;
- the individual policy must be of a type We commonly issue, but not one containing term or disability insurance or other added benefits;
- the individual policy will take effect at the end of the 31-day period after your group life insurance ends;
- the premium is based on Our rate for your class of risk and age at that time; and
- the amount of life insurance may not be more than the insurance that ceased under the Employee's Plan—less the amount of group life insur-

ance for which you become eligible during the 31 days after the date your group life insurance ends.

When the Group Policy or the Employer's Plan Ends or Changes

If you have been insured by the Employer's Plan at least five years, you may convert this group life insurance to an individual policy, provided:

- the life insurance ends because the group policy or the Employer's Plan ends; or
- the Employer's Plan is changed to end life insurance for the class to which you belong.

The conversion is subject to the same terms as in the section above, except that the amount of life insurance may not be more than the lesser of:

- $10,000; or
- the amount of group life insurance you had on the date the Employer's Plan ended or changed—less the amount of group life insurance for which you become eligible during the first 31 days after the date the Employer's Plan ends or changes.

Effect of Group Policy on Conversion Coverage

A specific rule applies if you convert to an individual policy and then die either:

- while Life Insurance is continued under the Continuance of Insurance provision; or
- while Life Insurance is extended under the Total Disability Benefit.

We will only pay the benefits under the Employer's Plan if the individual policy is surrendered to Us with no claim —other than a return of premium, less any debt.

## EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT

### ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Accidental Death and Dismemberment Insurance insures you against a loss as shown below. The loss must result from an accident, directly and independently of all other causes. The accident must take place while you are insured by this benefit. Also, the loss must take place within 90 days after the accident.

The most We will pay for all losses as the result of one accident is the Principal Sum shown in the Schedule of Benefits. We will pay benefits in accord with the Payment of Benefits—Beneficiary provision in the General Provisions.

The following table shows the benefit amounts We will pay:

| For Loss of: | Benefit: |
|---|---|
| LIFE | Principal Sum |
| BOTH HANDS OR BOTH FEET OR SIGHT OF BOTH EYES | Principal Sum |
| ONE HAND AND ONE FOOT | Principal Sum |
| ONE HAND AND SIGHT OF ONE EYE | Principal Sum |
| ONE FOOT AND SIGHT OF ONE EYE | Principal Sum |
| ONE HAND OR ONE FOOT OR SIGHT OF ONE EYE | 1/2 The Principal Sum |

Loss of hands and feet means severance at or above the wrist or ankle joint. Loss of sight means total and irrecoverable loss of sight.

We will pay twice the Principal Sum for the loss of life due to an injury while you are a fare paying passenger on:

- ground or water conveyance operated by a licensed common carrier; or

- an aircraft on a scheduled commercial flight, operated by a licensed common carrier.

CONTINUANCE OF INSURANCE

If you go on an approved leave of absence or a temporary layoff, or are Totally Disabled, your Accidental Death and Dismemberment Insurance may continue until the first of these events takes place:

- the date the group policy or the Employer's Plan ends;
- the date the group policy or the Employer's Plan is changed to end insurance for the class to which you belong;
- the date the Employer stops paying the premium for your insurance;
- the date the leave or layoff or Total Disability ends; or
- the date the leave or layoff or Total Disability has lasted three months.

The Employer must decide when to continue or stop the premium, within the limits explained above. The Employer must not single out any one Employee for special treatment.

LIMITATIONS

No benefit will be paid for a loss caused in any way by:

1. bodily or mental illness or infirmity, or infection—except:
   - a pyogenic infection from an accidental wound; or
   - an infection from the accidental ingestion of a poisonous food substance.

2. suicide or intentional self-inflicted injury while sane or insane.
3. war or act of war, rebellion, or taking voluntary part in a Riot.
4. military service for any country or organization, including service with military forces as a civilian whose duties do not include combat.
5. taking part in a felony.
6. air travel, other than as a fare paying passenger on a scheduled commercial flight.

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## COMPREHENSIVE MEDICAL INSURANCE

### BENEFIT PERIOD

A Benefit Period begins each January 1. It ends on the start of the next Benefit Period.

### MEDICAL DEDUCTIBLE

The Medical Deductible applies to each insured person for each Benefit Period. The Medical Deductible is equal to the sum of:

- the Cash Deductible shown in the Schedule of Benefits; and
- the benefits payable under any other plan the Employer sponsors or contributes to—provided the Expense is an Eligible Expense under these provisions.

### CASH DEDUCTIBLE PROVISIONS

The Cash Deductible has these special provisions:

- Three Month Carry-over: Any portion of the Cash Deductible applied during the last three months of a Benefit Period also applies for the next Benefit Period.
- Common Accident: When two or more insured family members are injured in the same accident, only one Cash Deductible must be met for the resulting Expense during that Benefit Period.
- Family Deductible: No more than three persons from your family need meet the Cash Deductible in any one Benefit Period.

### MEDICAL BENEFIT

The Medical Benefit is paid for Eligible Expense incurred for an Injury or Sickness while insured. We will compute the Medical Benefit for each Benefit Period in this way:

- For Eligible Expense subject to the Coinsurance Limit: First, the Medical Deductible must be met. Next, for all Eligible Expense up to the Coinsurance Limit, We will pay an amount equal to the Eligible Expense times the proper Coinsurance Factor. Then, for all Eligible Expense in excess of the Coinsurance Limit, We will pay an amount equal to the Eligible Expense.
- For Eligible Expense not subject to the Coinsurance Limit: First, the Medical Deductible must be met. Then, We will pay an amount equal to the Eligible Expense times the proper Co-insurance Factor.

The Coinsurance Limit and the Coinsurance Factors are shown in the Schedule of Benefits.

In no event may the Medical Benefit exceed the proper maximum shown in the Schedule of Benefits.

MAXIMUM BENEFIT

Out-Patient Psychiatric Treatment Maximum

The maximum benefit applies to the treatment of mental illness or nervous disorders on an out-patient basis. Benefits paid for each person will not be more than the Out-Patient Psychiatric Treatment Maximum shown in the Schedule of Benefits.

Medical Maximum

The Medical Benefit for each insured person may not exceed the Medical Maximum shown in the Schedule of Benefits. The amount of Medical Maximum available to an insured person is reduced by the amount of Medical Benefit paid. At the start of each Benefit Period, a reduced Medical Maximum will be increased by the lesser of:

- $1,000; or
- the total amount of the Medical Benefit paid.

ELIGIBLE EXPENSE

Eligible Expense means the following types of Expense incurred for an Injury or Sickness while insured:

Hospital Expense

Eligible Hospital Expense is that incurred for:

1. Room and Board for each day of a Hospital stay—but only up to four times the Hospital's most common semiprivate rate.
2. a stay in an intensive care unit—but only up to four times the Hospital's most common semiprivate room rate.
3. Miscellaneous Services received while confined.
4. these Miscellaneous Services on an out-patient basis:
   - emergency medical treatment within 72 hours of an injury;
   - medical care and treatment received on the day of and in connection with surgery; and
   - Pre-Admission Tests or Exams.

There is a limit on Expenses due to mental illness or nervous disorders. Only a total of 60 days of staying in a Hospital or an Extended Care Facility in each Benefit Period will be an Eligible Expense. Any days past these 60 days will not be an Eligible Expense.

Surgical Expense

Eligible Surgical Expense is that incurred for:

1. services of a Physician for performing surgery.
2. services of an anesthesiologist.

Medical Expense

Eligible Medical Expense is that incurred for:

1. charges made by a Hospital for Miscellaneous Services—but only if they have not been considered as Hospital Expense.
2. Physician's services other than for surgery.
3. the services of a radiologist or pathologist.
4. emergency transportation that is:
   - within or between the United States, Canada, and Puerto Rico;
   - by a licensed ambulance service, regularly scheduled airline, air ambulance, or railroad; and
   - from the place of Injury or Sickness to the nearest Hospital able to provide needed treatment.
5. anesthesia, oxygen, or other gases and the rental of equipment to administer them.
6. the services of a licensed physical therapist, registered nurse, or Christian Science nurse listed in the current issue of the Christian Science Journal, except for one who:
   - lives in the insured person's home; or
   - is the insured person's spouse, child, brother, sister, or parent.
7. x-ray or lab exams.
8. radiation therapy treatment.
9. drugs or medicines that may be obtained only upon written prescription by a Physician.
10. casts, splints, surgical dressings, or trusses.
11. the rental cost—up to the purchase price—of crutches, wheelchairs, hospital beds, or iron lungs.
12. initial prosthetic or orthopedic devices such as artificial limbs, eyes, or braces for a loss or injury which

occurs while the person is insured; and the replacements of these devices only when required by the insured person's growth to maturity.

13. blood transfusions—including the cost of whole blood or plasma not donated or replaced.
14. the first pair of glasses or contact lenses, but not both, needed after cataract surgery.
15. charges for Home Health Care by a Home Health Care Agency—but only to the first 100 visits in each Benefit Period.
16. charges made by an Ambulatory Surgical Center for performing surgery.
17. Room and Board and Miscellaneous Services for an eligible stay in an Extended Care Facility—but only up to a total of 120 days in each Benefit Period.

    A stay in an Extended Care Facility is covered only if:

    - the stay begins within 14 days after a Hospital stay of at least three consecutive days;
    - the stay is due to the same or related causes as the Hospital stay; and
    - a Hospital stay would otherwise be needed.

There is a limit on Expense due to mental illness or nervous disorders. Only a total of 60 days of staying in a Hospital or an Extended Care Facility in each Benefit Period will be an Eligible Expense. Any days past these 60 days will not be an Eligible Expense.

## CONTINUANCE OF INSURANCE

If you go on an approved leave of absence or temporary layoff, or are Totally Disabled, your Medical Expense Insurance may continue until the first of these events takes place:

- the date the group policy or the Employer's Plan ends;
- the date the group policy or the Employer's Plan is changed to end insurance for the class to which you belong;
- the date the Employer stops paying the premium for your insurance;
- the date the leave or layoff or Total Disability ends; or
- the date the leave or layoff or Total Disability has lasted three months.

If the Employer chooses to keep paying for your insurance, the Employer must also keep paying for your Dependents' Insurance, if any.

The Employer must decide when to continue or stop paying the premium, within the limits explained above. The Employer must not single out any one Employee for special treatment.

EXTENSION OF BENEFIT

We will pay the Medical Benefit after a person's insurance ends, if:

- the person is Totally Disabled on the day the insurance ends;
- the person stays Totally Disabled until the Expense is incurred;
- the Expense is directly related to the Total Disability;
- the Expense is incurred within 12 months after the day insurance ends; and
- the person has not become insured by another group plan offering essentially the same coverages.

LIMITATIONS

No benefit will be paid for Expense incurred for or in connection with:

1. intentionally self-inflicted Injury or Sickness while sane or insane.
2. war or act of war, rebellion or taking voluntary part in a Riot.
3. military service for any country or organization, including service with military forces as a civilian whose duties do not include combat.
4. taking part in a felony.
5. Injury or Sickness for which the insured person is not under the Regular Care of a Physician.
6. Injury or Sickness covered under any Workers' Compensation or Occupational Disease Law.
7. services or supplies from a government-owned or operated Hospital—unless a charge must be paid by the insured person.
8. services of a Physician employed by any government —unless a charge must be paid by the insured person.
9. charges to the extent that they are in excess of the Reasonable and Customary Charges for services or supplies.
10. charges for unnecessary care or treatment or care not uniformly or professionally endorsed as standard medical care.
11. eye refractions, glasses, contact lenses, hearing aids, or exams for their prescription or fitting—except the first pair of either glasses or contact lenses needed after cataract surgery.
12. Custodial Care.

13. cosmetic surgery, unless it is performed as soon as medically feasible and it is needed for:
    - the repair of an injury received while the person is insured;
    - the reconstruction that is incidental to or follows surgery resulting from an injury or Sickness; or
    - the correction of a congenital defect that results in a functional defect of an insured child.
14. routine or preventative medical care—other than for a complaint of an injury or Sickness.
15. Dental Care or Treatment, unless the Expense is for the following:
    - repair or replacement, within one year after injury or damage, to sound natural teeth that were harmed while insured;
    - remove tumors or cysts;
    - extract impacted teeth; or
    - Room and Board or Miscellaneous Services incurred while the insured person is confined in a Hospital for the care or treatment of this condition.
16. medical care or treatment given by the spouse, child, brother, sister, or parent of the insured person or spouse.
17. alcoholism, unless the Expense is incurred while the insured person is confined in a Hospital for the care or treatment of this condition.
18. drug addiction, unless the Expense is incurred while the insured person is confined in a Hospital for the care or treatment of this condition.
19. a Pre-Exsiting Condition.
20. pregnancy, except for Complications of Pregnancy.

21. an abortion, unless:
    - the insured person would be in danger if the fetus were carried to term; or
    - medical complications have resulted from an abortion.

## EFFECT OF MEDICARE

If an insured person incurs Expense:

- for an injury or Sickness while insured; and
- for which the insured person is entitled to benefits under Medicare, then:
  - —We will reduce Our payment by the amount Medicare would pay; and
  - —We will not pay any benefit if the amount Medicare would pay equals or exceeds Our benefit.

This will happen even if the insured person did not enroll in the entire Medicare program.

## COORDINATION OF BENEFITS

### Definitions

'Allowable Expense' means any Expense which is:

- for Reasonable and Customary Charges; and
- covered at least in part by one or more of the Plans under which the person is insured.

When a Plan provides services directly, the reasonable cash value of each service is deemed to be both an Allowable Expense and a benefit paid.

'Claim Determination Period' means a full or partial calendar year, during which the person for whom claim is made is insured under This Plan.

'Plan' means any policy, contract, or other arrangement to pay the cost of medical or dental care. This includes:

- group or blanket insurance;
- any hospital or medical service plan for prepaid group coverage;
- labor-management trusteed plans, union welfare plans, employer organization plans, employee benefit organization plans, and professional association plans;
- any other employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended; and
- government programs, including compulsory no-fault automobile insurance but excluding Medicare, unless an applicable law forbids coordinating benefits with this type of program.

'This Plan' means the Employer's Plan.

Effect on Benefits

The Coordination of Benefits provision assures that the total benefits paid from all Plans are not more than the actual Allowable Expenses. This includes all benefits that a Plan would pay if a claim were made, whether or not the claim is filed.

Order of Benefit Determination

If a person is insured under This Plan and another Plan at the same time, the Plans will pay benfits in this order:

- Any Plan that has no coordination of benefits provision will pay first.
- Plans that have a coordination of benefits provision will then pay as follows:

  —First: Any Plan in which the covered person is not insured as a dependent.

  —Second: Any Plan in which the covered person is insured as the dependent of a male.

—Third: Any Plan in which the covered person is insured as the dependent of a female.

However, other rules apply if a claim is made for an insured dependent child whose parents are separated or divorced:

- If the parent with custody of the child has not remarried, the Plans will pay in this order:

  —First: Any Plan in which the child is insured as a dependent of the parent who has custody.

  —Second: Any Plan in which the child is insured as a dependent of the parent who does not have custody.

- If the parent with custody of the child has remarried, the Plans will pay in this order:

  —First: Any Plan in which the child is insured as a dependent of the parent who has custody.

  —Any Plan in which the child is insured as the dependent of the stepparent.

  —Third: Any Plan in which the child is insured as the dependent of the parent who does not have custody.

These rules do not apply when a court decree fixes the resposibilities for the health care costs of a child whose parents have separated or divorced. Any Plan in which the child is insured as the dependent of a parent with this legal responsibility will always pay first.

In some cases, the order of payment may be unclear. Priority then goes to the Plan which has covered the insured person for the longest continuous time.

Right to Receive and Release Needed Information

We will have the right to obtain or give information needed to coordinate benefit payments with other Plans. This can be from or to any other insurance company,

organization, or person. We need not give notice or get anyone's consent to do this.

Any person who claims benefits must give Us the information We need to coordinate benefit payments.

Right to Make Payments

We have the right to pay any other organization as needed to properly carry out this provision. These payments that We make in good faith are considered benefits paid under This Plan. Also, they discharge Us from further liability to the extent the payments are made.

Right of Recovery

If We paid more than We should have, We have the right to recover the excess amount. This can be from the person for whom the payments were made. It can also be from any other insurance company or organization.

CONVERSION PRIVILEGE

When Group Medical Expense Insurance Ends

A person whose Medical Expense Insurance ends may be eligible to buy health insurance coverage from Us. To do this, the person does not have to give Us proof of good health. However, the conversion is subject to all of these terms:

Employees

You can convert this group insurance if:

- you have been insured at least three months in a row by the Employer's Plan or the plan it replaced;
- the group insurance did not end because the group policy or the Employer's Plan is being replaced by another insurer; and
- the group insurance did not end because the Employee Contribution Agreement was cancelled.

Dependents

An insured dependent can convert this group insurance if:

- you convert and your dependent converts at the same time;
- you die; or
- your dependent is no longer eligible for this group insurance.

Conditions of Issuance for Conversion Coverage

In order for the conversion coverage to be issued, the person must:

- not be eligible for Medicare or Canadian Federal or Provincial medical insurance plans;
- not be eligible for similar benefits under any other plan of group insurance; and
- apply in writing and pay the first premium within the later of:

  —31 days after insurance under the Employer's Plan ends; or

  —15 days after the person is given notice of this conversion privilege—but not later than 60 days after this group insurance ends.

The conversion coverage will be effective the day after this group insurance ends. The form, benefits provided, premium, and other terms of the conversion coverage will be in accord with all state laws and regulations which apply. We reserve the right to have the conversion coverage issued by another insurance company.

## GENERAL PROVISIONS

### DEFINITIONS

'Actively at Work' or 'Active Work' means that active Employees are doing all of the main duties of their job with the Employer where these duties are normally carried out.

'Ambulatory Surgical Center' means a licensed surgical or medical center operating within the scope of its license.

'Complications of Pregnancy' means any or all of the following:

- separate conditions made worse or caused by pregnancy, such as:

  —acute nephritis;

  —nephrosis;

  —cardiac decompensation;

  —missed abortion; and

  —other medical problems of similar severity.

- these conditions which occur during a pregnancy:

  —hyperemesis gravidarum;

  —ectopic pregnancy that is ended;

  —non-elective Caesarean section; and

  —spontaneous end of pregnancy which occurs when a viable birth is not possible.

'Complications of Pregnancy' does not include:

- false labor;
- occasional spotting;
- rest prescribed by a Physician;
- morning sickness;

- pre-eclampsia; or
- similar conditions that are associated with a difficult pregnancy but not classified as a distinct Complication of Pregnancy.

'Contribution Agreement' means an agreement an Employee signs which permits payroll deduction for Contributory insurance.

'Contributory Insurance' means Employees' Insurance or Dependents Insurance toward which an Employee must contribute.

'Custodial Care' means care designed mainly to help a person with daily living activities. It is not care primarily intended to help a person recover from an injury or Sickness.

'Dental Care or Treatment' means services or supplies for the teeth and their supporting tissues and structures.

'Dependents' Insurance' means insurance the Employer's Plan provides for an insured Employee's eligible dependents.

'Employee' means a person in an eligible class.

'Employees' Insurance' means insurance the Employer's Plan provides for an insured Employee.

'Employer' means a corporation, partnership or individual proprietorship participating in the Policyholder Trust.

'Employer's Plan' means the plan of insurance that is provided to insured Employees of the Employer under the group policy issued to the Policyholder Trust.

'Expense' means a charge a person is legally obligated to pay. 'Expense' is deemed to be incurred on the date the service or supply is furnished. We apply 'Expense' in the order incurred.

'Extended Care Facility' means a licensed institution, other than a Hospital, which provides:

- in-patient medical care and treatment to convalescing patients;
- treatment for mental illness or nervous disorders;
- full-time supervision by at least one Physician or registered nurse;
- 24-hour nursing service by licensed professional nurses;
- complete medical records for each patient; and
- utilization review plans for all patients.

An 'Extended Care Facility' also includes:

- any Christian Science Extended Care Facility accredited by the Department of Care of the First Church of Christ, Scientist, in Boston; and
- any Extended Care Facility which meets the Medicare definition, if the patient is eligible for Medicare.

'Home Health Care' means the services and supplies shown below. The Home Health Care must replace a needed Hospital stay or a stay in an Extended Care Facility. Also, it must be for the care or treatment of sick or injured persons and must be:

- ordered in writing by the insured person's Physician; and
- provided in the insured person's home by a Home Health Care Agency team.

Home Health Care consists of these services and supplies:

- part-time or intermittent home nursing care from or supervised by, a registered nurse;
- part-time or intermittent home health aid services;
- physical therapy, occupational therapy, and speech therapy; and

- medical supplies, drugs and medications prescribed by a Physician, and laboratory services—but only to the extent that they would have been covered in a Hospital or Extended Care Facility.

Each visit from a Home Health Care Agency team of four hours or less is considered a single visit.

'Home Health Care Agency' means a public or private agency that:

- specializes in giving nursing or therapeutic services in the home;
- is licensed as a Home Health Care Agency; and
- operates within the scope of its license.

'Hospital' means a licensed institution, other than an Extended Care Facility, that provides in-patient medical care and treatment for sick and injured persons. Services provided by a 'Hosptial' must also include all of the following:

- facilities for diagnosis of injury and Sickness on its premises;
- full-time supervision by at least one Physician;
- 24-hour nursing service by registered nurses;
- surgery or formal arrangements for available surgical facilities; and
- therapeutic care of patients who are convalescing from injury or Sickness.

The surgery rule will be waived if:

- treatment or services are provided for:

  —mental illness; or

  —rehabilitation from an illness; and
- the institution would otherwise qualify as a 'Hospital'.

'Hospital' also includes:

- any Christian Science sanatorium accredited by the Department of Care of the First Church of Christ, Scientist, in Boston; and
- any hospital, psychiatric hospital, or tuberculosis hospital which meets the Medicare definition, if the patient is eligible for Medicare.

'Injury' means bodily harm which is caused by an accident. It includes all injuries received in any one accident.

'Medical Expense Insurance' means any insurance provided under the Comprehensive Medical Expense Insurance Provisions.

'Medicare' means the medical care program described in Title XVIII of the Social Security Act of 1965, as amended.

'Miscellaneous Services' means medically necessary services and supplies, other than Room and Board and professional services. These services or supplies must be provided by a Hospital or Extended Care Facility.

'Non-Contributory Insurance' means insurance toward which an Employee does not contribute.

'Physician' means a person who is:

- licensed or legally authorized to give medical care or treatment; and
- acting within the scope of the license or authorization.

'Physician' also means an accredited Christian Science practitioner listed in the current issue of the Christian Science Journal.

'Pre-Admission Test or Exams' means tests or exams made before an insured person enters the Hospital for inpatient surgery, when:

- the tests or exams pertain to the planned surgery;
- the tests or exams are ordered by a Physician;
- the Physician requests Hospital admission of the insured person for surgery, and the Hospital confirms the request; and
- the Hospital admits the insured person within seven days after the test or exam results are known.

The seven-day rule will be waived if:

- the planned Hospital stay is cancelled; or
- a change in the person's condition precludes the need for surgery.

'Pre-Existing Condition' means an injury or Sickness for which an insured person received medical advice or treatment during the 90-day period before the person's insurance began under the Employer's Plan. An injury or Sickness will no longer be considered a 'Pre-Existing Condition' when the first of these events takes place:

- no medical advice or treatment for the condition is received for 90 days. This 90 day period must end while the person is insured by the Employer's Plan.
- If the person is an Employee, the Employee has been insured by the Employer's Plan for six months in a row.
- if the person is a dependent, the dependent has been insured by the Employer's Plan for 12 months in a row.

'Reasonable and Customary Charges' means charges that do not exceed the usual amount charged in the locality for similar services or supplies. They must be needed for the care of an insured person and be in keeping with the extent of the Injury or Sickness.

'Regular Care' means ongoing medical supervision or treatment which is in keeping with the nature of the Injury or Sickness involved.

'Riot' means all forms of public violence, disorder, or disturbance of the peace by a group of three or more persons. It does not matter whether:

- there was common intent; or
- there was intent to damage any person or property, or break the law.

'Room and Board' means the following charges to inpatients by a Hospital or Extended Care Facility:

- a bed;
- meals; and
- the general services essential to daily medical care.

'Service Requirement' means an unbroken period of Active Work.

'Sickness' means these conditions:

- when the body's organs do not function normally;
- when a temporary ailment reduces the body's ability to function normally;
- with respect to Life Insurance, pregnancy; or
- with respect to Medical Expenses Insurance, Complications of Pregnancy.

'Totally Disabled' or 'Total Disability' means an Injury or Sickness that results in:

- active Employees being unable to perform:
  - —with respect to Life Insurance, the main duties of any occupation or business; and
  - —with respect to all other coverages, the main duties of their normal occupation or business; or

- any other insured persons being unable to engage in the normal activities, duties, or responsibilities of healthy people of the same age and sex.

## ENTIRE CONTRACT

The entire contract consists of:

- the group policy;
- the Policyholder's application;
- the Employer's application; and
- the Employees' applications, if any.

Any statement the Policyholder, the Employer or you make is deemed a representation and not a warranty. We cannot use a statement by the Policyholder to void the group policy or deny a claim, unless the statement is in a written application signed by the Policyholder and attached to the group policy. We cannot use a statement by the Employer to void the Employer's Plan or to deny a claim, unless the statement is in a written application signed by the Employer. We cannot use a statement by or for an insured person to deny a claim, unless the statement is in a written application signed by you.

## POLICY CHANGES

We and the Policyholder may agree to change the group policy at any time. All changes must:

- be in writing;
- be signed by Our President, Vice President, Secretary, or Assistant Secretary.
- be signed by the Policyholder; and
- be in accord with the laws of the state where the group policy was delivered.

We and the Employer may agree to change the Employer's Plan at any time in accord with the terms of the group

policy. No agent may change the group policy or the Employer's Plan or waive any of the provisions of either.

## CONFORMITY WITH THE LAW

If any provison of the group policy or the Employer's Plan at time of issue is contrary to any law to which it is subject, the provision is changed to meet the law's minimum requirement.

## EMPLOYEE CERTIFICATES

We will provide a certificate for the Employer to deliver to each insured Employee. The certificate will:

- summarize the main features of the insurance; and
- state to whom the benefits will be paid.

## MISSTATEMENTS OR CLERICAL ERROR

If an insured person's true age has not been given, We will adjust the premium or the amount of benefit in this way:

- if the premium is based on age, the Employer must pay the premium required for the person's true age; and
- if the amount of benefit is based on age, the person will have the full amount of benefit the true age calls for, in this case, the Employer must pay Us the correct premium for the person's true age.

A clerical error will not void insurance which should be in force. Nor will it continue insurance which should have ended. When an error is found, We will make a fair adjustment in the premium.

## INCONTESTABILITY

We may contest the validity of the group policy after it has been in force for more than two years from the date of issue only if the premium has not been paid.

We may contest the validity of the Employer's Plan after it has been in force for more than two years from the effective date only if the premium has not been paid.

We may contest the validity of a person's insurance after the insurance on that person has been in force for more than two years during the person's lifetime only if the premium has not been paid for that person.

However, with respect to Life Insurance, this provision does not preclude the assertion at any time of defenses based on provisions in the group policy which relate to eligibility for coverage.

Your statements can be used to contest insurance on you and your dependents if:

- the statement is in a written application signed by you; and
- you or your beneficiary, if any, received a copy of the application.

## NO EFFECT ON WORKERS' COMPENSATION

The provisions of the group policy or the Employer's Plan are not in lieu of and do not affect any requirement for Workers' Compensation Insurance.

## INFORMATION TO BE FURNISHED

Whenever We require, the Employer shall provide information needed to administer the Employer's Plan. We have the right to inspect the Employer's records related to the Employer's Plan at any reasonable time.

## ASSIGNMENT

The benefits of the Employer's Plan may be assigned. We do not guarantee any assignment to be valid under this or any other plan.

## NOTICE OF CLAIM—NOT APPLICABLE TO LIFE INSURANCE

Written Notice of Claim must be given to Us within 20 days after a loss, or as soon as reasonably possible.

The Notice must:

- identify you as the insured Employee; and
- be given to Our Home Office or to an authorized agent.

## PROOF OF CLAIM—NOT APPLICABLE TO LIFE INSURANCE

When We receive the Notice of Claim, We will send Proof of Claim forms to the claimant. If We do not send the forms within 15 days after We receive the Notice of Claim, the claimant may file the Proof of Claim without special forms. The Proof of Claim must be in writing and explain the occurrence, character, and extent of the loss.

Written Proof of Claim must be given to Us within 90 days after:

- the filing of the Notice of Claim for Accidental Death and Dismemberment benefits; or
- for all other benefits, the end of the period for which We are liable.

If it is not reasonably possible to file the Proof of Claim within this time, We will allow more time. The Proof of Claim must then be filed as soon as possible, but not more than one year after We would normally require it. The one year rule will be waived if the claimant is not legally capable of filing earlier.

## PAYMENT OF BENEFITS—BENEFICIARY

Subject to the Coordination of Benefits and Facility of Payment provisions, all benefits will be paid as stated below.

All benefits, except for loss of life, will be paid to the assignee, if any, and otherwise to you.

All benefits other than those paid on a recurrent basis, will be paid as soon as We receive due written Proof of Claim.

We will pay any benefits for a loss of your life to the beneficiary on file at Our office. If you have named more than one beneficiary, We will do this:

- We will follow the instructions on the beneficiary designation on file at Our office; or
- if there are no instructions, We will divide the benefits equally among the named beneficiaries.

You may change a beneficiary by filing a written request with Us. Once We record it, the change becomes effective on the day you signed the request. However, if the change has not been recorded, payment will be made to the beneficiary We have on file. To the extent that payment has been made, We will have no obligation to any new beneficiary.

We will pay benefits to your estate if:

- you have not named a beneficiary; or
- there is no beneficiary living at the time of your death.

A person who applies for an individual life insurance conversion policy may choose a different beneficiary than the one last named for the Employer's Plan. When this happens, We will consider this to be a change of beneficiary under the Employer's Plan.

We do not guarantee a beneficiary designation to be valid or sufficient under this or any other plan.

## FACILITY OF PAYMENT

If a benefit is to be paid to your estate, or to a minor or other person that We consider legally incompetent, We will do this:

- We will first see if a request for payment has been received from a duly appointed guardian or other legally appointed representative.
- if no such request has been received, We may choose to pay an amount not to exceed $2,000 with respect to Life Insurance or $1,000 with respect to all other coverages to:

  —your spouse, or any blood relative of yours or of your beneficiary; or

  —any other person or institution whom We deem to be equitably entitled to the payment.

Any of these payments made in good faith will discharge Us from any liability to the extent that these payments are made. We will pay any remaining proceeds in accord with the Payment of Benefits—Beneficiary Provision.

## LEGAL ACTIONS

No lawsuits to recover under the group policy or the Employer's Plan may be filed:

- within the 60 days after Proof of Claim has been given; or
- more than three years after Proof of Claim must be filed.

## PHYSICAL EXAMS AND AUTOPSY

We may have a Physician examine any person who has an injury or Sickness which results in a claim. We may do this as often as We may reasonably require. With respect to Accidental Death and Dismemberment Insurance, We also have the right to have an autopsy performed if it is permitted by law. We will pay for the exams or autopsies which We request.

## FINANCIAL PROVISIONS

### PREMIUM DUE DATE

The first premium is due on the effective date of the Employer's Plan. Each remaining premium is due on the first of the month, known as the due date. The Employer is to pay the premiums at Our Home Office on or before the due date.

### GRACE PERIOD

After the first premium is paid, the Employer has a 31-day Grace Period to pay a premium due. Unless the Employer gives Us notice in writing of an intent to end the Employer's Plan, it will remain in force during the Grace Period. If the premium is not paid by the end of the Grace Period, the Employer's Plan will automatically end.

When the Employer's Plan ends, the Employer is liable for all premiums due and unpaid. This includes a pro rata premium for the time the Employer's Plan is in force during the Grace Period.

### PREMIUM CALCULATION

For each Employer, We determine the total premium for each due date from the premium rates then in effect for persons insured under that Employer's Plan.

### CHANGE OF EMPLOYER'S PLAN AND PREMIUM RATES

We have the right to change the coverages, benefits and premium rates on any due date. However, We must notify the Employer in writing 31 days before any change.

We also have the right to change the premium rates on the effective date of any change to the Employer's Plan.

## EXHIBIT 6

[20] Q Did—was an application filled out for an insurance policy, initially, when it was written?

A Yes.

Q Do you have a copy of that application in your file?

A No, I don't.

Q Is that something that you would have sent to Northbrook?

A Yes.

Q Do you know if they still have a copy of it?

A That, I don't know.

Q When the application was filled out, was that something that you did upon meeting with the Hibmas?

A I filled that out with Bob Hibma, in his office at Prescott Glass.

Q Was anyone else present when that occurred?

A No.

* * * *

[22] Q Did you speak—when you called up to give the quotation back did you speak with Bob Hibma or Sharon Hibma?

A Bob.

Q Then an appointment was set up to meet.

Did that follow through?

A Yes, we made out the application in his office.

Q Okay.

And were there any other meetings that you had with either Bob or Sharon Hibma when the policy was set up?

A No.

I did meet with them to deliver the package, after it was accepted, and that I gave to Bob.

Q Okay.

Was Sharon present at that time?

A No.

Q That delivery, then, of the package, would have been after this March 31st, 1987 date?

A Yes, I would assume so.

* * * *

[Dated June 15, 1992]

IN THE SUPERIOR COURT
OF THE STATE OF ARIZONA
IN AND FOR THE COUNTY OF MARICOPA

---

No. CV 90-11325

ROBERT HIBMA and SHARON HIBMA, on their own behalf and guardians of their child, MICHAEL HIBMA, a minor,
*Plaintiffs,*

vs.

ALLSTATE INSURANCE COMPANY, an Illinois corporation; DOES I through X; BLACK and WHITE CORPORATIONS I through V,
*Defendants.*

---

STATEMENT OF FACTS IN SUPPORT OF PARTIAL MOTION FOR SUMMARY JUDGMENT

Plaintiffs, ROBERT, SHARON and MICHAEL HIBMA, through undersigned counsel, and pursuant to Rule 56, Arizona Rules of Civil Procedure, file this Statement of Facts in support of their Motion for Summary Judgment which is filed herewith.

1. ROBERT and SHARON HIBMA purchased group health insurance for themselves and their children from ALLSTATE LIFE INSURANCE. (Admitted in Defendant's Answer.)

2. The insurance policy was purchased on April 1, 1987 for coverage of up to $1,000,000 per insured person per lifetime. (Relevant portions of the policy are attached as Exhibit No. 1.)

3. On February 15, 1988, MICHAEL HIBMA, the minor son of ROBERT and SHARON HIBMA was in-

volved in a vehicular accident that left him suffering from permanent injuries which rendered him paralyzed. ROBERT and SHARON HIBMA presented the claim to ALLSTATE and for a period of time ALLSTATE paid his medical expenses without objection. (Admitted in Defendant's Answer; See also excerpts from deposition of Bob Lee attached as Exhibit No. 6.)

4. On February 17, 1989, ALLSTATE informed the HIBMA's that they had "decided to withdraw from the group insurance market" and intended to terminate the policy. (Exhibit No. 2 attached.)

5. The HIBMA's contacted Bob Lee, the ALLSTATE agent with whom they had done business for many years. Based on their conversations with Bob Lee, Plaintiffs understood that ALLSTATE would not terminate the insurance coverage for MICHAEL'S injuries which resulted from the February 15, 1988 accident and which occurred during the time period that MICHAEL was covered under the policy. Indeed, the HIBMA'S understood that coverage would continue so long as they continued to pay the premium. (Affidavits of Plaintiffs attached hereto as Exhibit No. 3.)

6. Despite Plaintiff's conversation with Bob Lee, and the policy language to the contrary, the policy was unilaterally terminated by ALLSTATE on May 1, 1989. (See Exhibit No. 4, ALLSTATE letter regarding termination of coverage.)

7. ALLSTATE discontinued paying the claim and began denying payments in June of 1989. (See Exhibit No. 5, multiple correspondence by ALLSTATE denying claims for family members.)

8. The insurance policy delivered to the HIBMA'S specifically provides that:

> "The end of insurance will *not* effect any claim under dependent's medical insurance for a loss that took place while the insurance was in force."

(See Exhibit No. 1 at page 5 [red tab], emphasis added.)

9. The agent who sold the policy admitted in his deposition that he explained to ROBERT and SHARON HIBMA prior to issuing the policy that the policy had a $1,000,000 lifetime benefit. (See Exhibit No. 6, deposition of agent Bob Lee at page 33.)

10. Agent Bob Lee did not discuss the policy with ROBERT or SHARON HIBMA at the time he delivered it to them. (Exhibit No. 6 at pages 32, 33, 34 and 102.) In fact, the agent who sold the policy understood the policy to provide payment of benefits if there was a loss or injury up to the amount of the $1,000,000 benefits. The salesman who sold the policy explained that the word "loss" simply meant an illness or injury that was sustained by the insured. The agent admitted never having any discussions with the HIBMA'S at the time the policy sold [sic] as to what constituted a loss. (Lee deposition at pages 31, 34 and 35.) Indeed, agent Bob Lee *expected* that MICHAEL would receive benefits of up to $1,000,000 when he learned that MICHAEL was hurt. (Lee deposition at page 40.)

11. Agent Lee further admitted that at the time he sold the policy, he did not know what would occur in the event a policy ended while someone had suffered a loss for which benefits were being paid under the policy. Thus, the expectation of the agent who sold the policy as of the time of its sale to the HIBMA'S was that coverage would be provided to a person such as MICHAEL HIBMA and benefits paid for an illness or injury sustained by any insured. (Lee deposition at page 36.) The agent stated that he did not have a copy of the policy which he sold in his office. (Lee deposition page 66.)

12. When agent Lee first learned about MICHAEL being insured, it was his "expectation" that the benefits under the policy were payable for treatment up to the $1,000,000 limit available in the policy.

13. Agent Lee testified that upon receiving notification that the HIBMA'S policy was being terminated, he did

not have any understanding as to what would happen with respect to payments for MICHAEL HIBMA'S loss due to paralysis. Lee admitted he "didn't have any understanding of any kind." (Lee deposition page 49.)

14. Lee admitted that as of the date of the policy was sold the issue of whether benefits would be paid for a loss that occurred while the policy was in force, after the termination date, was never discussed with the insured at the time that the policy was sold and delivered. (Lee deposition at page 71.)

14. [sic] Even as of the date that the policy was terminated, Bob Lee admitted that he "didn't have any expectation" as to whether or not ALLSTATE would pay benefits for MICHAEL'S loss after the termination date of the policy. (Lee deposition pages 81-82.)

DATED this 15 day of June, 1992.

PLATTNER VERDERAME, P.C.

/s/ Frank Verderame
FRANK VERDERAME

## STATUTORY PROVISIONS

**ERISA § 3(1), 29 U.S.C. § 1002(1):**

For purposes of this title:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 302(c) of the Labor Management Relations Act, 1947 (other than pensions on retirement or death, and insurance to provide such pensions).

**ERISA § 3(3), 29 U.S.C. § 1002(3):**

(3) The term "employee benefit plan" or "plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.

**ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D):**

FIDUCIARY DUTIES

(a)(1) Subject to sections 403(c) and (d) [1103(c) and (d)], 4042 [1342], and 4044 [1344], a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

* * * *

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this title and Title IV.

**ERISA § 502(a), 29 U.S.C. § 1132(a):**

CIVIL ENFORCEMENT

(a) A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 409 [1109];

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of [section] 105(c) [1025(c)];

(5) except as otherwise provided in subsection (b), by the Secretary (A) to enjoin any act or practice which violates any provision of this title, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this title;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), or( 5) of subsection (c) or under subsection (i) or (l);

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 609 (a)(2)(A) [1169(a)(2)(A)]);

(8) by the Secretary, or by an employer or other person referred to in section 101(f)(1) [1021(f)(1)], (A) to enjoin any act or practice which violates subsection (f) of section 101 [1021], or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

**ERISA § 514(a), 29 U.S.C. § 1144(a):**

EFFECT ON OTHER LAWS

(a) Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) [1003(a)] and not exempt under section 4(b) [1003(b)]. This section shall take effect on January 1, 1975.

**29 C.F.R. § 2510.3-1(j):**

(j) *Certain group or group-type insurance programs.*

For purposes of Title I of the Act and this chapter, the terms "employee welfare benefit plan" and "welfare plan" shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which

(1) no contributions are made by an employer or employee organization;

(2) participation in the program is completely voluntary for employees or members;

(3) the sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoff and to remit them to the insurer; and

(4) the employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.

Supreme Court, U.S.
FILED
MAY 2 1997

No. 96-1476

In The

# Supreme Court of the United States

October Term, 1996

ALLSTATE LIFE INSURANCE COMPANY,

*Petitioner,*

*v.*

MICHAEL HIBMA, *et al.*,

*Respondents.*

*On Petition for a Writ of Certiorari to the Court of Appeals of the State of Arizona*

## RESPONDENTS' BRIEF IN OPPOSITION

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## TABLE OF CONTENTS


| | *Page* |
|---|---|
| Table of Citations | ii |
| Statement of the Case | 1 |
| A. Procedural History | 1 |
| B. Correction of Misstatements in the Petition | 3 |
| 1. Introduction | 3 |
| Reasons for Denying the Writ | 3 |
| I. The Decision Below Is An Unpublished State Court Memorandum Decision And Is Not Binding On Anyone Except Allstate And The Hibmas. | 3 |
| II. The Unpublished Memorandum Decision Will Not Create Confusion In Arizona Or Otherwise. | 4 |
| III. The Unpublished State Court Memorandum Decision Will Not Create Conflict Among The Federal Circuits. | 4 |
| IV. Review Of The Unpublished Decision Will Not End Perceived Conflict In ERISA's Plan Coverage. | 5 |
| V. The Unpublished Arizona Decision Determines No Federal Questions, But Rather Ends Litigation Between Two Parties. | 6 |
| Conclusion | 7 |

*Contents*

*Page*

## TABLE OF CITATIONS

**Cases Cited:**

*Asarco, Inc. v. Industrial Comm'n*, 594 P.2d 107 (Ariz. Ct. App. 1979), *appeal after remand*, 619 P.2d 27 ..... 3, 4

*Blue Cross/Blue Shield of Florida, Inc. v. Weiner*, 543 So.2d 794 (Fla. Ct. App. 1989), *review denied*, 553 So.2d 1164, *cert. denied*, 494 U.S. 1028 (1990), *aff'd by abstention in collateral proceeding*, 730 F. Supp. 674 (D. Md. 1990), *aff'd*, 925 F.2d 81 (4th Cir. 1991), *cert. denied*, 502 U.S. 816 (1991) ..... 5

*First Interstate Bank v. Dep't of Revenue*, 916 P.2d 1149 (Ariz. Ct. App. 1995), *review denied* ..... 3, 4

*Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1 (1986) ..... 6

*Harnischfeger Corp. v. Harbor Ins. Co.*, 927 F.2d 974 (7th Cir. 1991), *rehearing denied, cert. denied*, 112 S. Ct. 189, 502 U.S. 864, 116 L. Ed. 2d 150 ..... 4

*Morrison v. Burlington Industries*, 282 S.E.2d 458 (N.C. 1981) ..... 4

*People of Territory of Guam v. Yang*, 850 F.2d 507 (9th Cir. 1988) ..... 4

*Contents*

*Page*

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Ariz. R. Civ. App. P. 28(c) ..... 3

Respondents, Prescott Glass Corporation, Michael Hibma, Robert Hibma, and Sharon Hibma, on their own behalf and as guardians of Michael Hibma, a minor, request that this Court deny the petition for writ of certiorari seeking review of an unpublished order of the Arizona Court of Appeals entered March 14, 1996 and supplemented on May 21, 1996.

## STATEMENT OF THE CASE

Respondents respectfully oppose the petition for writ of certiorari because the order for which review is sought is an unpublished memorandum decision and is binding only on the parties thereto, *i.e.*, Allstate and the Hibmas.

### A. Procedural History

Respondents own a one-employee business in Prescott, Arizona. They arranged for group health insurance for the family and the one employee from Allstate Insurance Company. In 1988, the Hibmas' son, Michael, was permanently and severely injured in an accident. In 1989, Allstate terminated coverage of the Hibmas. The Hibmas sued Allstate in Arizona Superior Court for breach of contract and bad faith. Allstate contends that this is an ERISA case and, hence, is preempted. The family contends that this is a state common law matter. Allstate moved for summary judgment, which was denied by the trial court. The Arizona Court of Appeals affirmed in an unpublished opinion "because that question turns on an unresolved question of fact." (Appendix to Petition for Writ of Certiorari, 7a). Before appeal, the parties entered into a high-low agreement whereby Allstate was to pay the Hibmas the low figure if the case was governed by ERISA and the high figure if governed by state law. A condition of payment for the high figure was that the ERISA issue had to be decided "on the merits." Because it was unclear from the first Court of Appeals opinion whether the ERISA issue

was decided "on the merits," both parties requested clarification and the court issued a supplemental memorandum opinion. Resolving any questions of fact in Allstate's favor, the Court of Appeals decided the ERISA issue on the merits and in the Hibmas' favor. It opined:

> We now decide the issue on the merits. We conclude under the circumstances of this case, even assuming that Prescott Glass paid all or part of the premiums for Hull [Prescott Glass' sole employee, other than the Hibmas], ERISA does not apply. . . .
>
> * * *
>
> On the record as it most strongly favors Allstate in this case, we can say that the regulatory concerns of ERISA are not implicated.

Appendix to Petition for Certiorari, 2a-4a.

The Court of Appeals also noted, cumulatively, that the employer's role was "so negligible, so lacking in anything meaningful to the enforcement of ERISA policy, that preemption does not apply in this case." (Appendix to Petition for Certiorari, 12a).

The Arizona Supreme Court denied Allstate's petition for review.

**B. Correction of Misstatements in the Petition**

*1. Introduction*

Petitioner's introduction overstates the Arizona Court of Appeals' holding. The court simply held that ERISA does not apply "under the circumstances of this case." (Appendix to Petition for Writ of Certiorari, 2a). The appellate decision does not contain the broad language stated in the first sentence of the Petition's introduction. In addition, Allstate's statement that "[t]he ruling, moreover, was not confined to small or medium-sized employers; it applies across the board to all employers" is also incorrect. The ruling was confined to this particular employer and Allstate.

## REASONS FOR DENYING THE WRIT

### I.

### THE DECISION BELOW IS AN UNPUBLISHED STATE COURT MEMORANDUM DECISION AND IS NOT BINDING ON ANYONE EXCEPT ALLSTATE AND THE HIBMAS.

The Arizona Rules of Civil Appellate Procedure provide that memorandum decisions are not regarded as precedent and they are not to be cited except to establish a *res judicata* defense, collateral estoppel, or law of the case. Ariz. R. Civ. App. P. 28(c); *First Interstate Bank v. Dep't of Revenue*, 916 P.2d 1149, 1153 (Ariz. Ct. App. 1995), *review denied*, (stating that citing an unpublished decision is improper and declining to consider the decision); *Asarco, Inc. v. Industrial Comm'n*, 594 P.2d 107, 110 (Ariz. Ct. App. 1979), *appeal after remand*, 619 P.2d 27 (holding that memoranda decisions should not be cited as authority).

Further, it is highly unlikely that the result in Hibma would even occur again given its unique set of facts.

## II.

## THE UNPUBLISHED MEMORANDUM DECISION WILL NOT CREATE CONFUSION IN ARIZONA OR OTHERWISE.

Arizona courts will not consider the unpublished decision as precedent. *First Interstate Bank*, 916 P.2d at 1153; *Asarco*, 594 P.2d at 110. Other states will not consider an unpublished Arizona decision as precedent, first, because they will not have access to it, and, secondly, because state court decisions are not binding precedent on other states. *Morrison v. Burlington Industries*, 282 S.E.2d 458, 470 (N.C. 1981). Therefore, Petitioner's claim that review is necessary to resolve confusion created by the unpublished opinion is unfounded.

## III.

## THE UNPUBLISHED STATE COURT MEMORANDUM DECISION WILL NOT CREATE CONFLICT AMONG THE FEDERAL CIRCUITS.

Federal courts are not required to follow state precedent unless it is published. *Harnischfeger Corp. v. Harbor Ins. Co.*, 927 F.2d 974, 976 (7th Cir. 1991), *rehearing denied, cert. denied*, 112 S. Ct. 189, 502 U.S. 864, 116 L. Ed. 2d 150. Moreover, the Ninth Circuit does not consider its own unpublished opinions as precedent. *People of Territory of Guam v. Yang*, 850 F.2d 507, 511 (9th Cir. 1988). If the Ninth Circuit will not rely on its own unpublished opinion, it is highly unlikely it will consider an unpublished *state court* opinion.

## IV.

## REVIEW OF THE UNPUBLISHED DECISION WILL NOT END PERCEIVED CONFLICT IN ERISA'S PLAN COVERAGE.

The decisions cited as evidence of a conflict are misleading, as is Petitioner's statement that "Arizona is one of the many states" expressing dissatisfaction with ERISA. Petitioner cites cases from seven states. Seven out of fifty hardly constitutes a majority. Additionally, Petitioner notes that the state decisions are contrary to the "law in the majority of the circuits." The conflict, if any, between state court decisions and the circuit law could have been resolved on earlier petitions for certiorari; however, this Court chose not to grant certiorari. *Turnbow v. Pacific Mut. Life Ins. Co.*, 765 P.2d 1160 (Nev. 1988), *cert. denied*, 490 U.S. 1102 (1989); *Blue Cross/Blue Shield of Florida, Inc. v. Weiner*, 543 So.2d 794 (Fla. Ct. App. 1989), *review denied*, 553 So.2d 1164, *cert. denied*, 494 U.S. 1028 (1990), *aff'd by abstention in collateral proceeding*, 730 F. Supp. 674 (D. Md. 1990), *aff'd*, 925 F.2d 81 (4th Cir. 1991), *cert. denied*, 502 U.S. 816 (1991); *Sayble v. Blue Cross of Southern Calif.*, 256 Cal. Rptr. 820 (1989), *overruled by Marshall v. Bankers Life & Cas. Ins. Co.*, 2 Cal. 4th 1045, 10 Cal. Rptr. 2d 72, *cert. denied*, 506 U.S. 1000 (1992). Any conflict in how courts are determining the existence of an ERISA plan would have been apparent in the difference between *Weiner* and *Marshall*. Yet, the Court declined review of both cases.

## V.

## THE UNPUBLISHED ARIZONA DECISION DETERMINES NO FEDERAL QUESTIONS, BUT RATHER ENDS LITIGATION BETWEEN TWO PARTIES.

Petitioner argues that unless the unpublished Arizona decision is reversed, it will have "a significant adverse impact on (literally) millions of insured employee benefit plans across the country." This statement is untrue. The only significant adverse impact of this unpublished decision is on Allstate's pocketbook. The "practical effect" of the decision is not to "void ERISA's carefully crafted . . . enforcement schemes," but rather, to force Allstate to honor its settlement agreement with the Hibmas. As the Arizona Court of Appeals put it: "The order of the trial court is affirmed, and under the terms of the agreement entered into between the parties, the Hibmas are entitled to payment of the greater amount called for by the agreement." (Appendix to Petition for Writ of Certiorari, 4a).

This Court has already provided guidance to employers, participants, beneficiaries, and administrators on the necessary elements for ERISA coverage. *See Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 9 (1986). No further guidance from this Court is needed, especially on a case with a unique factual background which formed the basis of the settlement agreement between the parties.

## CONCLUSION

For the foregoing reasons, the petition for writ of certiorari should be denied.

Respectfully submitted,

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MOTION FILED
MAY 15 1997

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No. 96-1476

IN THE
# Supreme Court of the United States
OCTOBER TERM, 1996

ALLSTATE LIFE INSURANCE COMPANY
*Petitioners*,

v.

MICHAEL HIBMA, *et al.*,
*Respondent*.

**On Petition for a Writ of Certiorari to the Court of Appeals of the State of Arizona**

## MOTION TO FILE BRIEF *AMICI CURIAE* AND BRIEF *AMICI CURIAE* OF THE AMERICAN COUNCIL OF LIFE INSURANCE AND THE HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF THE PETITION

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## MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE* FOR THE AMERICAN COUNCIL OF LIFE INSURANCE AND THE HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF THE PETITION

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The American Council of Life Insurance ("ACLI") and the Health Insurance Association of America ("HIAA") hereby move, pursuant to Rule 37.2 of the Rules of this Court, for leave to file the attached brief as *amici curiae*. Counsel for the petitioner has consented to the filing of this brief; counsel for the respondent has refused consent.

ACLI represents 557 member companies that underwrite most of the nation's life insurance. HIAA represents more than 250 health insurance companies that cover more than 60 million Americans. These companies frequently serve as administrators or claims fiduciaries of employee benefit plans.

Defining which rules of law govern employee benefit plans and plan administrators is of vital importance to ACLI and HIAA. The state court decision below and others like it—which hold that ERISA does not apply to plans that are arranged and paid for by the employer--through an independent insurance company, but that are not administered by the employer conflict with Congress's intent in ERISA, with the decisions of many federal courts of appeals, and with the Department of Labor's regulations construing ERISA. These state court decisions threaten to eliminate ERISA coverage for the most common variety of employee benefit plan.

As a result of their significant experience in administering such plans, *amici* bring a unique perspective to this case. As the attached brief seeks to demonstrate, decisions like the one below have created considerable confusion for plan administrators, including ACLI's and HIAA's member companies, as to whether their rights and obligations are to be governed by federal or state law.

For these reasons, the Court should grant this motion for leave to file the attached brief *amici curiae* in support of the petition for certiorari.

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## TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES . . . . . ii

INTEREST OF THE AMICI CURIAE . . . . . 1

INTRODUCTION AND SUMMARY . . . . . 2

REASONS FOR GRANTING THE PETITION . . . . . 4

I. THE CURRENT CONFUSION IN THE LAW DEFINING ERISA-COVERED PLANS UNDERMINES THE PURPOSES OF ERISA . . . . . 4

II. THE DECISION BELOW SHARPLY CONFLICTS WITH ESTABLISHED FEDERAL PRECEDENT REGARDING THE DEFINITION OF A PLAN UNDER ERISA . . . . . 6

III. THIS ISSUE IS RECURRING AND IMPORTANT . . . . . 9

CONCLUSION . . . . . 11

## TABLE OF AUTHORITIES

**Page**

**Cases**

*Belasco v. W.K.P. Wilson & Sons*, 833 F.2d 277 (11th Cir. 1987) . . . . . 8
*Blue Cross/Blue Shield of Florida, Inc. v. Weiner*, 543 So. 2d 794 (Fla. Ct. App. 1989), *cert. denied*, 494 U.S. 1028 (1990) . . . . . 7
*Brundage-Peterson v. Compcare Health Services Insurance Corp.*, 877 F.2d 509 (7th Cir. 1989) . . . . . 7, 9
*Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982) . . 8
*Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987) . . . . . 5, 9, 10
*Fugarino v. Hartford Life and Accident Insurance Co.*, 969 F.2d 178 (6th Cir. 1992), *cert denied*, 507 U.S. 966 (1993) . . . . . 8, 9
*Grimo v. Blue Cross/Blue Shield of Vermont*, 34 F.3d 148 (2d Cir. 1994) . . . . . 8
*Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990) . . . . . 4, 5, 10
*Kanne v. Connecticut General Life Insurance Co.*, 867 F.2d 489 (9th Cir. 1988), *cert. denied*, 492 U.S. 906 (1989) . . . . . 8, 9
*Kornman v. Blue Cross/Blue Shield of Louisiana*, 662 So. 2d 498 (La. Ct. App. 1995), *cert. denied*, 116 S. Ct. 2527 (1996) . . . . . 7
*Madonia v. Blue Cross & Blue Shield of Virginia*, 11 F.3d 444 (4th Cir. 1993), *cert. denied*, 511 U.S. 1019 (1994) . . . . . 8
*Massachusetts v. Morash*, 490 U.S. 107 (1989) . . . . . 8
*Memorial Hospital System v. Northbrook Life Insurance Co.*, 904 F.2d 236 (5th Cir. 1990) . . . . . 8
*Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359 (1980) . . . . . 4

## TABLE OF AUTHORITIES
(Continued)

**Page**

*New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 115 S. Ct. 1671 (1995) . . . . . 5
*Peters v. Boulder Insurance Agency, Inc.*, 829 P.2d 429 (Colo. Ct. App. 1991) . . . . . 7
*Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) . . . . . 10
*Qualls v. Blue Cross of Calif.*, 22 F.3d 839 (9th Cir. 1994) . . . . . 8
*Robertson v. Gem Insurance Co.*, 828 P.2d 496 (Utah Ct. App. 1992) . . . . . 6, 9
*Roe v. General America Life Insurance Co.*, 712 F.2d 450 (10th Cir. 1983) . . . . . 8
*Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983) . . . . . 4, 5
*Williams v. Wright*, 927 F.2d 1540 (11th Cir. 1991) . . . . . 8

**Statutes and Regulations**

The Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 . . . . . 1, 4
29 U.S.C. § 1144(a)(1994) . . . . . 4
29 U.S.C. § 1161(a) (1994) . . . . . 10
29 C.F.R. 2510.3-1 (1996) . . . . . 8

**Legislative History**

H.R. Rep. No. 94-1785, 94 Cong., 2d Sess. (1977) . . . . . 4
120 Cong. Rec. 29197 (1974) . . . . . 5
120 Cong. Rec. 29933 (1974) . . . . . 5

**Miscellaneous Authority**

Reorg. Plan No. 4 of 1978, 43 Fed. Reg. 47,713 (1978) . . 8

## INTEREST OF THE AMICI CURIAE[1]

The American Council of Life Insurance ("ACLI") and the Health Insurance Association of America ("HIAA") represent the nation's providers of life, disability, health, and other insurance. ACLI represents 557 member companies that underwrite most of the nation's life and disability insurance. HIAA represents more than 250 health insurance companies that cover more than 60 million Americans.

As insurers, ACLI's and HIAA's member companies are integrally involved in the provision of insurance benefits through employee benefit plans that are covered by ERISA. These companies frequently serve as ERISA plan administrators or claims fiduciaries. They consequently have a vital interest in legal questions affecting the interpretation of ERISA, in promoting uniform and consistent rules of ERISA plan administration and ERISA coverage, and in preserving uniformity in the interpretation of the definition of a plan under ERISA.

The legal and practical consequences of the Arizona Court of Appeals' decision, and others like it, are of grave concern to ACLI, HIAA, and their member companies. In holding that ERISA does not apply to employee medical insurance that an employer obtains and pays for through an insurance company, if the employer delegates to the insurance company the administration of the insurance benefits, these decisions would eliminate ERISA coverage of the most common variety of employee benefit plan. *See* Pet. 2 (noting that more than 148 million Americans are covered by private-sector employer-sponsored group health insurance similar to the coverage in this case). ACLI and HIAA seek to provide this Court with the unique perspective of their broad-based constituencies on this important federal question.

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[1] No counsel for any party had any role in authoring this brief, and no person other than the named *amici* and their counsel made any monetary contribution to its preparation and submission.

## INTRODUCTION AND SUMMARY

This case implicates an important and recurring issue under the Employee Retirement Security Act of 1974: whether an employer establishes an "employee benefit plan" within the scope of ERISA by selecting, applying for, and buying a health insurance policy for its employees—even if the employer does not administer the insurance policy itself, but instead delegates that task to the insurance company. The Arizona Court of Appeals held that an ERISA-covered plan was not established in these circumstances, and thus that an insured's state-law claims with respect to the insurance policy were not preempted by ERISA.

In 1987, the employer in this case, Prescott Glass, applied to Allstate Life Insurance Company for major medical group insurance to cover its two employees. Prescott paid the initial application fees and at least some of the monthly premiums as a benefit to the employees. Allstate administered Prescott's insurance program. As required by ERISA, Allstate provided Prescott and the employees with plan documents describing the medical insurance policy and the procedures for filing claims for benefits. Under the policy, Allstate had the right to terminate with 60 days' written notice. In 1989, Allstate exercised its rights under the policy and notified Prescott that it was terminating the policy, as it was withdrawing from the group health insurance market.

An individual who was covered under the insurance policy then filed this suit against Allstate in Arizona state court, asserting state-law causes of action for, *inter alia*, breach of contract, breach of fiduciary duty, bad faith, fraud, and negligence. Allstate moved for summary judgment on the ground that Prescott's insurance policy constituted an "employee welfare benefit plan" within the meaning of ERISA and, therefore, that ERISA preempted all of the plaintiff's state-law claims.

The trial court denied Allstate's motion, and the Arizona Court of Appeals affirmed, holding that Prescott did not establish an ERISA-covered plan by obtaining and paying for the Allstate insurance policy. The court reasoned that "garden variety

employee health insurance benefits" are not covered by ERISA, unless the employer, as opposed to the insurance company, engages in "administrative activity" with respect to those benefits. Pet. App. 3a-4a. Accordingly, because Prescott did not administer the insurance program at issue here, the court held that the plaintiff's state-law claims were not preempted. The Arizona Supreme Court denied review.

The questions presented by Allstate's Petition require the Court's attention for two reasons. First, the decision below undermines the congressional intent for ERISA of ensuring uniformity in the operation and regulation of employee benefit plans. This uniformity is, as Congress recognized, advantageous for all those who sponsor, administer, or participate in employee benefit plans. Under the approach taken by the Arizona courts in this case, state courts are given free rein to apply their own standards to determine whether an employee benefit plan is covered by ERISA, thereby opening the door to conflicting rules of law in the federal and state systems regarding the duties and liabilities of plans and plan administrators.

Second, the decision below, together with the similar decisions of other state appellate courts, squarely conflicts with the decisions of federal courts of appeals as to what constitutes an employee benefit plan covered by ERISA. It also conflicts with the Department of Labor's "safe harbor" regulations, which define when an employer's activity is too minimal to create an ERISA-covered plan. Without clarification by this Court of the proper standard to apply, neither plan administrators, nor plan sponsors, nor plan participants can have any certainty about their rights and obligations, thus undermining the purposes of an important federal statute.

## REASONS FOR GRANTING THE PETITION

### I. THE CURRENT CONFUSION IN THE LAW DEFINING ERISA-COVERED PLANS UNDERMINES THE PURPOSES OF ERISA

The Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 ("ERISA"), imposed a comprehensive scheme of federal regulation on plans established by employers to provide employees with fringe benefits. ERISA was designed to balance the interests of employees and their families in obtaining secure and well-administered benefits, with the interests of employers and plan administrators in having their duties with respect to such benefits clearly defined. To that end, Congress provided that the rights and obligations of all parties to ERISA-covered employee benefit plans were to be controlled by a single body of law—federal law. *See Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359, 361-362 (1980).

Section 514(a) of ERISA, 29 U.S.C. § 1144(a) (1994), contains a broad preemption provision. It exempts ERISA plans from "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan," with a few exceptions not at issue in this case. The sweep of this provision is expansive because Congress's purpose was to eradicate *any* potentially inconsistent state or local regulation of employee benefit plans. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 141 (1990).

The need for uniformity in the law governing employee benefit plans was a recurring theme in the congressional discussions following the enactment of ERISA. The House Report, for example, emphasized that "'the Federal interest and the need for national uniformity are so great that enforcement of state regulation should be precluded.'" *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 100 n.21 (1983) (quoting H.R. Rep. No. 94-1785 at 47, 94th Cong., 2d Sess. (1977)).

Indeed, this Court has recognized that Congress's "crowning achievement" in ERISA was its "reservation to Federal authority the sole power to regulate the field of employee benefit plans,"

thereby "round[ing] out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation." *Shaw*, 463 U.S. at 99 (quoting Representative Dent, one of ERISA's sponsors, *see* 120 Cong. Rec. 29197 (1974)). The elimination of inconsistency was "intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law." 463 U.S. at 99 (quoting Senator Williams, another ERISA sponsor, *see* 120 Cong. Rec. 29933 (1974)).

As the Court has observed, in preempting the field of employee benefit law for federal regulation, Congress accomplished several salutary purposes. These include "minimiz[ing] the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government" and preventing "the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction." *Ingersoll-Rand*, 498 U.S. at 142. For example, in the absence of ERISA's preemption provision,

> [a] plan would be required to keep certain records in some States but not in others; to make certain benefits available in some States but not in others; to process claims in a certain way in some States but not in others; and to comply with certain fiduciary standards in some States but not in others.

*Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987); *see also New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S. Ct. 1671, 1677-78 (1995) ("The basic thrust of the [ERISA] pre-emption clause, then, was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.").

The decision below, together with others like it, gives rise to precisely what Congress sought to avoid in ERISA: "conflicting and inconsistent State and local regulation" that, if allowed to stand, will necessitate "the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction." Such

a result cannot be reconciled with the plain language and legislative history of ERISA.

## II. THE DECISION BELOW SHARPLY CONFLICTS WITH ESTABLISHED FEDERAL PRECEDENT REGARDING THE DEFINITION OF A PLAN UNDER ERISA

Federal courts have, consistent with Congress's intent in ERISA, applied a broad construction of when an employer has "established or maintained" an employee benefit plan within the meaning of ERISA. But some state appellate courts have taken a much narrower approach, thereby exempting a large number of employee benefit programs from ERISA. These courts have, like the court below, construed ERISA to apply only to plans administered by the employer itself, as opposed to the vast majority of plans administered by insurance companies or other third parties. This construction of ERISA conflicts with the decisions of several federal courts of appeals, as well as with the regulations issued by the Department of Labor.

In this case, although the employer had obtained the group medical insurance policy for its employee and paid some or all of the premiums for their coverage, the Arizona Court of Appeals refused to find that an ERISA-covered plan had thereby been created. In so holding, the court accorded "critical importance" to the fact that the employer's own involvement in the administration of the plan was only "negligible." Pet. App. 3a, 4a, 12a. The Arizona court adopted this analysis from *Robertson v. Gem Insurance Co.*, 828 P.2d 496 (Utah Ct. App. 1992), which had likewise placed decisive weight on whether the employer itself was the administrator of the employee benefits. The Utah court had reasoned that "the regulatory concerns of ERISA are not implicated" where an employer, after setting up an employee benefit plan, does not engage in "administrative activity" with respect to the plan, but instead delegates administration to a third party. *Id.* at 502-03 (quotation omitted). Consistent with this case and *Robertson*, other state appellate courts, in assessing whether an employee benefit plan is covered

by ERISA, have focused on the extent of the employer's role in plan administration.[2]

A number of federal appellate decisions, in contrast, have recognized that an employee benefit plan is covered by ERISA, whether or not the employer administers the plan itself or delegates that task to an insurance company or other third party. A leading decision in this regard is *Brundage-Peterson v. Compcare Health Services Insurance Corp.*, 877 F.2d 509 (7th Cir. 1989), which held that an ERISA-covered plan existed on facts strikingly similar to those in this case.

In *Brundage-Peterson*, as here, the employer had arranged for medical insurance for its employees, paid the premiums for the employees' coverage, and delegated administration of the benefits to the insurers. Also as here, the plaintiff argued that these insurance benefits were not a "plan" under ERISA, and thus that state-law claims concerning those benefits were not preempted by ERISA. The Seventh Circuit, in an opinion by Judge Posner, recognized that even such a concededly "barebones" benefit plan came within the coverage of ERISA. *Id.* at 511. The court observed that ERISA "by its express terms encompasses the provision of [employee health and welfare] benefits by means of insurance"—a mechanism that necessarily entails little, if any, employer "participation in the actual provision of the benefits." *Id.* The court went on to observe that "delegation of administration of the plan to an insurance company" is "in fact contemplated by the statute." *Id.*

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[2] *See, e.g., Peters v. Boulder Ins. Agency, Inc.*, 829 P.2d 429 (Colo. Ct. App. 1991) (no ERISA coverage where employer did not maintain any significant administrative role in operation of group insurance plan); *Blue Cross/Blue Shield of Florida, Inc. v. Weiner*, 543 So. 2d 794 (Fla. Ct. App. 1989) (no ERISA coverage although employer obtained medical insurance policy for employees and paid premiums), *cert. denied*, 494 U.S. 1028 (1990); *Kornman v. Blue Cross/Blue Shield of Louisiana*, 662 So. 2d 498 (La. Ct. App. 1995) (no ERISA coverage where employer, after obtaining and paying for insurance, delegated administration to Blue Cross), *cert. denied*, 116 S.Ct. 2527 (1996).

Other federal courts of appeals have found ERISA-covered plans to exist in similar circumstances. For example, the Sixth Circuit has held that an employer establishes an ERISA-covered employee benefit plan simply by obtaining a medical insurance policy for its employees and paying the premiums on the policy. *Fugarino v. Hartford Life and Accident Ins. Co.*, 969 F.2d 178, 184 (6th Cir. 1992), *cert denied*, 507 U.S. 966 (1993). It was not necessary that the employer participate in the administration of the benefits. *Id.* The same approach to determining whether an employer has, in fact, established an ERISA-covered plan has been employed by the Second, Fourth, Fifth, Ninth, Tenth, and Eleventh Circuits.[3]

Not only does the decision below, together with *Robertson* and similar state appellate decisions, conflict with the decisions of eight federal circuits, but it also is inconsistent with the federal Department of Labor's "safe-harbor" regulation, 29 C.F.R. 2510.3-1(j) (1996), which provides guidance as to when an employer may assist its employees in obtaining their own insurance without being deemed to have created an ERISA-covered plan.[4] Under this regulation, an employer who obtains insurance for its employees will be deemed to have

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[3] *See, e.g., Grimo v. Blue Cross/Blue Shield of Vermont*, 34 F.3d 148 (2d Cir. 1994); *Madonia v. Blue Cross & Blue Shield of Virginia*, 11 F.3d 444 (4th Cir. 1993), *cert. denied*, 511 U.S. 1019 (1994); *Memorial Hospital Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990); *Qualls v. Blue Cross of Calif.*, 22 F.3d 839 (9th Cir. 1994); *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988), *cert. denied*, 492 U.S. 906 (1989); *Roe v. General Am. Life Ins. Co.*, 712 F.2d 450 (10th Cir. 1983); *Williams v. Wright*, 927 F.2d 1540 (11th Cir. 1991); *Belasco v. W.K.P. Wilson & Sons*, 833 F.2d 277 (11th Cir. 1987); *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982).

[4] The Department of Labor has the authority to interpret the provisions of Title I of ERISA. *See* Reorg. Plan No. 4 of 1978, 43 Fed. Reg. 47,713 (1978). *See also Massachusetts v. Morash*, 490 U.S. 107, 116-19 (1989) (giving deference to Labor Department's regulations in 29 C.F.R. § 2510.3-1 and its interpretations thereunder).

created an ERISA-covered plan *unless* the employer can satisfy each of four requirements. Among these requirements are that the employer pay no portion of the employees' insurance and that the employer's "sole function" be "to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs, and to remit them to the insurer." *Id.* While the federal courts of appeals have sought to define ERISA-covered plans consistently with this regulation—*see, e.g.*, *Fugarino*, 969 F.2d at 184; *Brundage-Peterson*, 877 F.2d at 511; *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489, 492-93 (9th Cir. 1988), *cert. denied*, 492 U.S. 906 (1989)—the court below and other state courts have disregarded the regulation, *see* Pet. App. 3 (quoting *Robertson*, 828 P.2d at 503).

In sum, the Seventh Circuit observed in *Brundage-Peterson* that, if the question whether a given employee benefit plan is covered by ERISA were left to the sort of "complicated, variable, case-by-case standard" applied below, the result would be unwarranted "uncertainty and litigation." 877 F.2d at 511. "Employers, employees, and insurance companies would have no clear idea whether their rights and obligations were defined by federal law or by state law." *Id.* Yet, the state appellate courts are creating that very "uncertainty" through decisions like the one in this case—decisions that cannot be reconciled with *Brundage-Peterson*, with the decisions of seven other federal courts of appeals, and with the "safe-harbor" regulation issued by the Department of Labor. This Court's intervention is necessary in order to resolve these two conflicting lines of authority.

## III. THIS ISSUE IS RECURRING AND IMPORTANT

The decision below, and the growing number of others like it, create the sort of "patchwork scheme of regulation" of employee benefit plans that, as this Court has recognized, gives rise to "considerable inefficiencies in [plan] operation." *Fort Halifax*, 482 U.S. at 11. These inefficiencies have severe consequences not only for insurance companies that administer employee benefit plans, but also for employers who have chosen to provide

employee benefits through insurance companies, and for employees and their families.

The members of ACLI and HIAA, who administer insured employee benefit plans, are most immediately affected by these decisions. They will be required to ascertain and comply not only with ERISA's extensive requirements, but also with potentially inconsistent state-law requirements in every jurisdiction where their plans operate. A single plan administered by one of these companies may, of course, operate in a number of states at the same time. Accordingly, these companies will be required, contrary to Congress's intent in ERISA, to "tailor[ ]" their plans, and their conduct in administering those plans, "to the peculiarities of the law of each jurisdiction." *Ingersoll-Rand*, 498 U.S. at 142. And, if they fail to do so to the satisfaction of the state courts, they may be subject to penalties, such as punitive damages, that are foreclosed under ERISA. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 53 (1987).

It is not only insurance companies and other plan administrators, however, that will bear the burdens of this confusion. In order to offset their costs of conforming to conflicting legal standards and their increased litigation exposure, insurers may have to raise premiums, curtail benefits, or even cease to do business in particular states. In turn, "those employers with existing plans [may] reduce benefits, and those without such plans [may] refrain from adopting them." *Fort Halifax*, 482 U.S. at 11.

Employees and other plan beneficiaries not only may suffer a reduction in their current insurance benefits as a result of decisions such as the one below, but also may lose the considerable protections afforded them by ERISA. For example, they would be deprived of their COBRA right to continued insurance coverage for a period after leaving employment. *See* 29 U.S.C. § 1161(a) (1994). The Arizona Court of Appeals' decision provides a road map for benefits providers to escape ERISA applicability for their plans. Employers need only delegate administrative authority to a third party in order to opt out of the

statute, effectively denying employees the very protections envisioned by ERISA.

Only this Court can finally resolve the confusion among the federal and state courts over what constitutes an ERISA-covered employee benefit plan. This important issue of plan definition should be decided now. It will only increase the costs and reduce the availability of employee benefits—to the detriment of employers, employees, and their families—to allow this issue to percolate any further in the lower courts.

## CONCLUSION

For the foregoing reasons, *amici* urge the Court to grant certiorari in this case.

Respectfully submitted,

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No. 96-1476

IN THE

# Supreme Court of the United States

OCTOBER TERM, 1996

ALLSTATE LIFE INSURANCE COMPANY,
*Petitioner,*

*vs.*

MICHAEL HIBMA, et al.,
*Respondents.*

ON PETITION FOR WRIT OF CERTIORARI
TO THE COURT OF APPEALS
OF THE STATE OF ARIZONA

## MOTION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF AND BRIEF *AMICUS CURIAE* OF THE ASSOCIATION OF CALIFORNIA LIFE AND HEALTH INSURANCE COMPANIES IN SUPPORT OF PETITIONER

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*Respondents.*

MOTION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF

The Association of California Life and Health Insurance Companies ("ACLHIC") respectfully requests leave to file the accompanying *amicus curiae* brief in support of Petitioner Allstate Life Insurance Company's ("Allstate") Petition for a Writ of Certiorari to the Court of Appeals of the State of Arizona. Counsel for Allstate has consented in writing to ACLHIC filing an *amicus curiae* brief; counsel for Respondents Michael Hibma et al. has declined to consent.[1]

ACLHIC is a California non-profit trade association whose members are domestic California life and health insurance companies. ACLHIC members also include foreign life and health insurance companies which do business in California. One of the primary purposes of ACLHIC is to represent the interests of its members, for their benefit and that of their policyholders, in substantial public policy matters which affect them. Many of ACLHIC's members insure

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[1] Petitioner Allstate has made a monetary contribution to the preparation and submission of the present motion and accompanying brief. This motion and accompanying brief have not been authored in whole or in part by counsel for any party.

employee welfare benefit plans and, as such, are directly impacted by the decision of the Court of Appeals of the State of Arizona's decision in this action (and the denial of review by the Arizona Supreme Court) (hereafter "the Decision"). The Decision is premised in large part on an erroneous and overruled decision of the California Court of Appeal in *Sayble v. Blue Cross of Southern California*, 256 Cal.Rptr. 820 (1989) (depublished by order of the California Supreme Court dated June 8, 1989), and therefore is of further interest to ACLHIC.

At stake are the uniform regulation and certainty of the administration and remedies which lie at the heart of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Decision is in conflict with the decisions of United States Courts of Appeals, and the controlling California law set forth in a decision of the California Supreme Court issued subsequent to *Sayble*. The Decision also decides an important question of federal law in a way that conflicts with relevant decisions of this Court concerning the breadth and scope of ERISA. This Court should clarify the all-important test for determining when an ERISA plan exits. It should reject the conclusion of the Court of Appeals of the State of Arizona that the uniform protection of ERISA plan participants under

federal law, preemption of dissimilar laws of the several states and the scope of permissible remedies available to participants is to be determined by whether the employer establishing the plan engages in administrative conduct sufficient to invoke "ERISA policy."

For the foregoing reasons, ACLHIC respectfully requests leave to file the accompanying *amicus curiae* brief.

Dated: May 16, 1997

Respectfully Submitted,

By: J. Russell Stedman


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## TABLE OF CONTENTS


STATEMENT ..... 1

INTEREST OF *AMICUS CURIAE* ..... 1

SUMMARY OF ARGUMENT ..... 2

ARGUMENT ..... 4

1. The Court Should Grant The Petition For A Writ Of Certiorari To Establish A Clear Test For When An Employee Benefit Plan Is Subject To ERISA And To Protect Uniformity Of ERISA Regulation ..... 4

2. The Court Of Appeals Of The State Of Arizona Has Created An Improper Requirement That An Employer Must Engage In "Meaningful" Administration Of An Employee Welfare Benefit Plan In Order For ERISA To Apply ..... 8

CONCLUSION ..... 15

## TABLE OF AUTHORITIES

### CASES

*Credit Managers Ass'n v. Kennesaw Life & Acc. Ins. Co.*, 809 F.2d 617 (9th Cir. 1987) ..... 9

*Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1 (1987) ..... 5, 6, 10, 11, 12

*International Resources, Inc. v. New York Life Ins. Co.*, 950 F.2d 294 (6th Cir. 1991) ..... 9

*Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988) ..... 9

*Marshall v. Bankers Life & Cas. Ins. Co.*, 2 Cal.4th 1045, 10 Cal.Rptr. 72 (1992) ..... 13, 14

*Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) ..... 2

*Rizzi v. Blue Cross of Southern California*, 206 Cal.App.3d 380, 253 Cal.Rptr. 541 (1989) ..... 13

*Robertson v. Gen. Ins. Co.*, 828 P.2d 496 (Utah App. 1992) ..... 14

*Sayble v. Blue Cross of Southern California*, 256 Cal.Rptr. 820 (1989) ..... 2, 9, 10, 11, 13, 14

*Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983) ..... 6

### STATUTES

29 U.S.C. §1002(1) ..... 4, 9, 13, 14

California Rule of Court 977 ..... 13

### REGULATIONS

29 C.F.R. §2510.3-1(j) ..... 10

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## STATEMENT

The statement of this case is set forth in Allstate's Petition, which statement is adopted here.[1]

## INTEREST OF *AMICUS CURIAE*

The Association of California Life and Health Insurance Companies ("ACLHIC") is a California non-profit trade association whose members are domestic California life and health insurance companies. ACLHIC members also include foreign life and health insurance companies which do business in California. One of the primary purposes of ACLHIC is to represent the interest of its members, for their benefit and that of their policyholders, in substantial public policy matters which affect them. Many of ACLHIC's members insure employee welfare benefit plans and, as such,

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[1] Petitioner Allstate has made a monetary contribution to the preparation and submission of this brief. This brief has not been authored in whole or in part by counsel for any party.

are directly impacted by the decision of the Court of Appeals of the State of Arizona (the "Decision"). The Decision is premised in large part on an erroneous and overruled decision of the California Court of Appeal in *Sayble v. Blue Cross of Southern California*, 256 Cal.Rptr. 820 (1989) (depublished by order of the California Supreme Court dated June 8, 1989), and therefore is of further interest to ACLHIC.

## SUMMARY OF ARGUMENT

It would not be an overstatement to describe Allstate's Petition as presenting the most important issue concerning ERISA since *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). The question is whether this Court will sanction through silence an unfounded limitation on the application of ERISA to employee welfare benefit plans. The issue affects hundreds of millions of individuals and the majority of employee welfare benefit plans in this country. At stake are the Congressional goals of encouraging the formation and proper administration of welfare benefit plans, uniformity of application of ERISA, preemption of varying state laws, and securing ERISA rights and remedies for plan participants.

The insurance industry, employers and plan participants need clarity, certainty and uniformity of law. "Meaningful" administration by employers should not be required and could discourage the establishment of privately funded employee plans. Employers often arrange for insurance companies or other administrators to provide professional, specialized services to deliver plan benefits to their employees, a field with little or nothing to do with the employer's business. The employer should not be required to undertake some uncertain level of administration of the plan in order to bring it within ERISA, nor should the employer incur the inevitable increased costs associated with either assuming such administration, or establishing a benefit plan which may not be within the scope of ERISA and therefore subject to varying laws, remedies and rights.

ACLHIC, speaking on behalf of its insurance company members and the insurance industry, supports the Department of Labor and the United States Courts of Appeal which have determined that an ERISA plan is easily established. A plan should be recognized as subject to ERISA if it meets minimum standards and not tested by a subjective

case-by-case analysis of whether the employer's administration invokes some ERISA policy. The Decision is based on the erroneous, unfounded, depublished and overruled decision in *Sayble*, *supra*, and conflicts with the plain language of the statute which defines an ERISA plan, 29 U.S.C. §1002(1). The Petition for Review should be granted, and this Court should reject the limitations on ERISA that the Court of Appeals of the State of Arizona has created.

## ARGUMENT

### 1. The Court Should Grant The Petition For A Writ Of Certiorari To Establish A Clear Test For When An Employee Benefit Plan Is Subject To ERISA And To Protect Uniformity Of ERISA Regulation

Allstate's Petition presents the Court with the opportunity to establish a clear, uniform test for determining when ERISA governs an employee benefit plan. The scope and impact of ERISA regulation have been the subject of numerous decisions of the Court, but the threshold issue of when an ERISA plan has been established has not yet been squarely addressed.

The Court of Appeals of the State of Arizona has determined that the majority of America's employee health benefit plans--those where the employer simply purchases insurance and/or delegates administration to some other entity--are *not* covered by ERISA. The Decision creates troublesome and unwarranted distinctions based on employer activity. Congressional goals underlying the enactment of ERISA, and subsequent amendments to ERISA, will be eviscerated if the millions of smaller and medium-sized "garden-variety" employee benefit plans do not enjoy ERISA's protections.

To encourage the growth and development of employee benefit plans, Congress desired a unified system of regulation of plans to replace a patchwork of state and local rules and remedies. *See, Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 11 (1987). An important goal of ERISA is to encourage efficient administration of employee benefit plans because inefficiencies caused by conflicting state regulations might result in a lowering of benefit levels, elimination of benefits or benefits not being provided in the first instance.

*Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 105 n.25 (1983); *see also Fort Halifax*, *supra* at 11.

To accomplish ERISA's goals, employers, plan administrators and plan participants need clarity, certainty and uniformity of law. It is obvious that employers seek out insurance companies and plan administrators in order to obtain the benefit of professional, specialized administrative services:

> [O]ver 148 million individuals in the United States are covered by private sector employer-sponsor group health insurance that is virtually identical to the coverage in this case, and, for 91% of these plans, the employers do *not* handle plan administration.[2]

Requiring employer administration in order for ERISA to apply would discourage establishment of privately funded

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[2] Allstate's Petition, p. 2 (footnote omitted) (emphasis in original).

employee benefit plans and increase the costs of administration.[3] Plan administrators would face the unenviable task of weighing the quantity and quality of the employer administration in deciding whether or not ERISA applied. Assuming the plan administrator reached the correct conclusion, only then would it be able to properly administer the plan either under ERISA, or under one or more of the governing laws of one of 50 states. Resulting inefficiencies would cause increased premiums, reductions in benefits or inability of employers to obtain needed insurance. Such a result would not serve the purpose of ERISA, and in fact threatens the benefits of ERISA to participating American workers.

This Court should grant the Petition of Certiorari in order to establish with finality the test for determining whether

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[3] *See* Allstate's Petition, at n. 21, noting the substantially higher administrative expenses per participant for smaller plans.

a plan is one subject to ERISA. The need for uniformity is great, and the apparent minority trend focusing on employer administration is damaging.

### 2. The Court Of Appeals Of The State Of Arizona Has Created An Improper Requirement That An Employer Must Engage In "Meaningful" Administration Of An Employee Welfare Benefit Plan In Order For ERISA To Apply

The Court of Appeals of the State of Arizona has created a test succinct in description, but subjective, confusing and likely to result in widely varying applications:

> The line between and ERISA plan and a non-ERISA plan depends to some extent on the level of employer involvement that would justify federal regulation of plan administration . . . . If there is no potential for `employer abuses such a self-dealing, imprudent investing, and misappropriation of

plan funds,' the aims of ERISA are not a stake. (3a).[4]

The test created by the Arizona court contradicts the plain language of 29 U.S.C. §1002(1) which provides that a plan is subject to ERISA if "established and maintained" by the employer to provide certain types of benefits. No requirement of employer administration is included in that statute's definition of what constitutes an ERISA plan. The Ninth and the Sixth Circuits have held that an employer can establish an ERISA plan by doing nothing more than arranging a "group type insurance program." *Credit Managers Ass'n v. Kennesaw Life & Acc. Ins. Co.*, 809 F.2d 617, 625 (9th Cir. 1987); *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489, 492 (9th Cir. 1988) cert. den'd, 492 U.S. 906 (1989); *International Resources, Inc. v. New York Life Ins. Co.*, 950 F.2d 294, 297-98 (6th Cir. 1991), cert. den'd, 504 U.S. 973

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[4] Citations omitted. In the present case, the Court of Appeals of the State of Arizona found that the employer's involvement was "so negligible, so lacking in anything meaningful to the enforcement of ERISA policy, that preemption does not apply in this case." (14a)

(1992). The Department of Labor has adopted regulations which establish the minimal employer participation necessary to subject a plan to ERISA regulation. *See* 29 C.F.R. §2510.3-1(j). Despite this authority, the tremendous breadth of ERISA, and the Congressional goals promoted by uniformity of regulation, the Court of Appeals of the State of Arizona elected to follow questionable state law precedent with its genesis in *Sayble, supra*, a now depublished and overruled California Court of Appeal decision.

*Sayble* involved an aggressive and unwarranted attack upon ERISA, ruling that an employer must do much more than merely fund premium payments for group insurance in order for ERISA to apply. Without specifying what administrative activity the employer must engage in, the *Sayble* court concluded that absent an employer-operated plan, and the potential for employer abuses such as self-dealing, imprudent investing, and misappropriation of plan funds, the purposes of ERISA would not be served and ERISA would not apply. The *Sayble* decision, which effectively removed all non-employer administered benefit plans from ERISA, was predicated upon this Court's decision in *Fort Halifax*, *supra*.

*Fort Halifax* involved the issue of whether a *one-time* severance plan mandated by state law was preempted by ERISA. The court concluded that this single payment was not within ERISA because there was no *ongoing plan*:

> The requirement of a one-time lump sum payment triggered by a single event requires *no administrative scheme whatsoever to meet the employer's obligation.* The employer assumes no responsibility to pay benefits on a regular basis, and thus faces no periodic demands on its assets that create a need for financial coordination and control. Rather, the employer's obligation is predicated on the occurrence of a single contingency that may never materialize. *Fort Halifax*, *supra*, 482 U.S. at 12 (emphasis added).

*Fort Halifax* does not support the Decision or *Sayble's* conclusion. An employer paying insurance premiums for group coverage on behalf of its employees *does* face "periodic demands on its assets that create a need for financial

coordination and control." Moreover, employers who purchase group insurance must select the participants, handle enrollment, pay the premiums and therefore maintain financial integrity. Unlike *Fort Halifax*, the establishing and maintaining of a health benefit plan such as that in the present case involves an ongoing plan rather than a possible one-time payment "predicated on the occurrence of a single contingency that may never materialize."

Delegation of administrative activity to an insurer through the purchase of a policy and payment of premiums constitutes an ongoing plan and itself involves administrative activity. By definition, the insurer's investigation, consideration and payment or denial of submitted claims is administrative in nature. The mere fact that, as in over 90% of *all* employee benefit plans[5] the employer delegates administrative obligations to a third party as expressly permitted by ERISA, rather than doing them itself, should not determine whether an ERISA plan has been established.

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[5] Allstate's Petition, p. 2.

Significantly, *Sayble*, and its holding, are not even current California law. *Sayble* was depublished and cannot be cited or relied upon in proceedings before California courts. *See*, California Rule of Court 977. Sayble's legal conclusions were overruled by the California Supreme Court in *Marshall v. Bankers Life & Cas. Ins. Co.*, 2 Cal.4th 1045, 10 Cal.Rptr. 72 (1992), cert. den'd, 506 U.S. 1000 (1992).[6] There, the California court recognized application of ERISA to a plan with no employer activity beyond purchasing an insurance policy, contributing premiums and retaining authority to terminate the policy. *Marshall*, *supra*, 2 Cal.4th at 1057. The California Supreme Court rejected the "employer administration" test, noting that the language of 29 U.S.C. §1002(1) "does not support such a requirement," and that administration of plans is commonly delegated to an insurer or third-party administrator. *Marshall, supra*, 2 Cal.4th at 1052-53. The Court of Appeals for the State of Arizona's

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[6] *Marshall* also effectively overruled another California case relied upon by the Arizona Court of Appeal (3a) which had applied the "employer administration" test, *Rizzi v. Blue Cross of Southern California*, 206 Cal.App.3d 380, 253 Cal.Rptr. 541 (1989), cert den'd 493 U.S. 821 (1989).

reliance on *Sayble* and a decision of the Utah Court of Appeals[7] itself premised on *Sayble*, is unfounded.

This Court should take this opportunity to reject the "meaningful employer administration" test. It should establish the Department of Labor regulations as a minimal standard for application of ERISA, and recognize ERISA application whenever an employer has taken those minimal steps necessary to establish or maintain a benefit plan for its employees as defined in 29 U.S.C. §1002(1). This result will fully serve the Congressional goals of encouraging the establishment of welfare benefit plans, and the concurrent need for uniform regulation to achieve that goal.

## CONCLUSION

For the foregoing reasons, *amicus curiae* The Association of California Life and Health Insurance Companies urges this Court to issue a Writ of Certiorari to review the

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[7] *Robertson v. Gen. Ins. Co.*, 828 P.2d 496 (Utah App. 1992).

judgment and opinion of the Court of Appeals of the State of Arizona.

Dated: May 16, 1997

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## I.
## The proposed briefs fail to raise any issues which are new or different from those posed by the Petitioner.

Rule 37 of the Supreme Court Rules requires that an amicus brief bring new issues to the attention of the court. Generally, amicus briefs are not favored. Despite knowing that Respondents do not consent, amicus briefs have been filed which fail to raise even one new issue. Indeed, the amicus briefs so closely follow the language of the Petition that portions appear to be quoted verbatim. This failure to follow the Rules should cause the court to deny the motions to allow amicus briefs and Respondents respectfully request that the court disallow the briefs and strike them from the record.

## II.
## This case is so unique that neither petitioners nor their Amici have cited even one case which contains similar facts.

Several facts exist here which are ignored by Petitioner and Amici. These facts are unlike those from any case cited by them. To suggest that this case is "recurrent" is to ignore the following facts:

1) The insurance agent who represents Petitioner and sold the policy in question *admitted* in deposition that the policy he sold

was not part of an *ERISA* plan. Petitioner and Amici have failed to cite even one case in any brief where the insurance carrier's representative admits the insurance policy is not, and was not contemplated to be, an *ERISA* plan.

2) The Petitioner never adequately proved that an employer paid for an employee's policy. Nearly every case cited by Petitioner and Amici begins with the factual assumption that the employer has, at very least, paid to provide insurance for some employee. The courts below ruled that the burden of this proof on this issue rested with the Petitioner and that they failed to meet their burden.

3) The insured, putative employer, and agent agree that they never intended to create an *ERISA* welfare benefit plan. All individuals involved with the purchase of the Hibmas' insurance policy testified that they contemplated the mere purchase of insurance, nothing more. In all of the cases cited by Petitioner and Amici, the insurance carriers and their representatives consistently took the position that the benefits involved were issued under an *ERISA* plan. None of the cases cited by Amici involve a transaction where ***all*** of the parties are in agreement.

4) Early in the litigation Petitioner by its conduct made a judicial admission that Arizona law applies to the case. Early in

the litigation, Petitioner filed a Motion for Summary Judgment which claimed that Arizona law applied to the insurance policy in question and suggested that Arizona law required that Summary Judgment be granted. Respondents filed a Cross-motion for Summary Judgment which agreed that Arizona law applied and suggested that the law required that judgment be entered for the Respondents. The trial judge agreed with the Respondents, granted our motion, and denied the Petitioner's motion.

After losing that motion, and approximately 3 years into discovery and litigation, the Petitioner for the very first time claimed that the health insurance sold was not insurance but an *ERISA* "welfare benefit plan". The trial judge saw through this charade, as did the Arizona appellate courts.

Under Arizona law, Allstate's prior admission that this case involves an insurance policy constituted a judicial admission which bound the Defendant and prohibited it from taking a contrary position later. See, Buehman v. Smelker 50 Ariz. 18, 68 P.2d 946 (1937), Brenteson Wholesale, Inc. v. Arizona Public Service 166 Ariz. 519, 803 P.2d 930 (App. 1990); Moore v. Blackstone 20 Ariz. 328, 180 P.2d 526 (1919); Fridenmaker v. Valley National 23 Ariz. App 565, 534 P.2d 1064 (1975); and others. See also, definition of "Judicial Admission" in Black's Law Dictionary.

Thus, under the facts of this case, not only did all of the parties to the transaction contemplate that this was a simple sale of a personal insurance policy, but so did Allstate's lawyers. Is there even one case from the federal circuits which contains such an admission as a part of its facts? What could be more unique?

6) Defendant has cited some case law to suggest correct documentation and government filings are not necessary to establish an *ERISA* plan. And, it is true that prior to litigation **nothing** whatsoever was done by anyone, including the defendant, to document or indicate in any way that an *ERISA* welfare benefit plan existed. But, in this case the company, its agents and everyone involved agreed that this insurance policy was not an *ERISA* plan **and** that there was **no documentation** to even suggest that this was a welfare benefit plan. In this case the lack of documentation supports the testimony. In the cases cited by Amici and Petitioner, the documentation conflicts with the testimony.

7) The impact of this case will go no farther than the parties involved here. The Arizona Appellate Court opinion is unpublished. Under the Arizona rules, therefore, the case cannot be cited as precedent. (See Brief in Opposition to Petition for Writ of Certiorari.)

8) The decision of the Arizona Court of Appeals pertains to a

specific settlement agreement between the parties. The court's supplemental memorandum opinion makes it clear that its decision is limited to the particular settlement agreement entered into between the Hibma family and Allstate--no one else is involved.

**Conclusion**

For anyone to take the position that this case addresses a recurring set of facts is ludicrous. This case is unique. The party admissions are unique. The case history is unique and the terms of the parties' settlement agreement is unique. The Amici have failed to cite any case law or any facts in this case that make it suitable as precedent. If this Supreme Court were to grant review, its opinion would have limited value as precedent due to the peculiar and unusual facts presented here. The facts are so unique that this case does not approach Pilot Life or any of the other federal court issues involving *ERISA*.

DATED May 29, 1997

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